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AUTHOR	Posner, Marc
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ABSTRACT

This volume is a guide to providing effective Human Immunodeficiency Virus (HIV) and substance abuse prevention services to runaway and homeless youth. The guide is based on current research and the best programs in this field. Chapters 1 and 2 summarize what is known about runaway and homeless youth, the services these youth require if they are to reduce their risk behaviors, and the challenges of integrating HIV prevention activities into existing programs. Chapter 3 on program planning covers: developing goals and policies for programs, assessing needs, designing prevention activities, distributing condoms, educating staff and volunteers, evaluating prevention activities, and implementing HIV antibody testing. Chapters 4 through 6 use a case study approach to describe three types of programs: (1) those that serve the "street youth" of larger cities (Los Angeles Youth Network, Urban Peak in Denver, Colorado, and Streetwork Project in New York, New York); (2) short-term crisis intervention services (The Bridge for Runaway Youth in Minneapolis, Minnesota, and Huckleberry House in Columbus, Ohio); and (3) a system of comprehensive care for runaway and homeless youth coordinated by the Division of Adolescent Medicine of the Childrens Hospital of Los Angeles. The guide includes a bibliography and list of resources. (Contains 214 references.) (JB)

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NOWHERE TO RUN

HIV Prevention for Runaway and Homeless Youth

Staff

Education Development Center, Inc.
Principal Investigator: Marc Posner, Ph.D.
Project Director: Peggy Enright
Research Associate: Daphne Northrop
Senior Administrative Assistant: Betty Chouinard

National Network for Runaway and Youth Services
Executive Director: Della Hughes
Director of Public Policy: Nevarez Nichols
Director, Safe Choices Project: Jay Coburn
Director, Youth-Reaching-Youth Project: Patty Dietz

NOWHERE TO RUN:
HIV PREVENTION FOR RUNAWAY AND HOMELESS YOUTH

Marc Posner

Prepared by
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02160
(617) 969-7100
(800) 225-4276

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INTRODUCTION

The term "runaway" is capable of conjuring up two very different images. The first is the fresh-faced youth with a peanut-butter-and-jelly sandwich tied up in a handkerchief who leaves home to join the circus, but makes it only as far as grandma's house. The second is the sullen-faced youth in tight-fitting jeans standing on a city street-corner and offering sex to passersby to earn enough money to buy food or drugs.

Although both of these stereotypes contain some truth, neither tells the whole story of what it means to be a runaway youth in contemporary America. Many young people leave home for a night at grandma's after a trivial dispute with their parents. However, a significant number of youth run from, or are forced out of, severely dysfunctional families: families characterized by conflict, violence, and sexual abuse.

Runaway and homeless youth have always faced many threats to their well-being, including sexual exploitation, substance abuse, violence, and a host of physical and emotional dangers. In the last decade a new threat has appeared: acquired immunodeficiency syndrome (AIDS). If agencies serving runaway and homeless youth are to be effective at improving the well-being of their clients, they must find ways to protect them from human immunodeficiency virus (HIV) infection. And this means preventing or reducing injectable drug use, unprotected sexual activity, and the abuse of alcohol and other drugs (which often precedes sexual activity).

The purpose of *Nowhere to Run* is to help administrators of agencies that serve runaway and homeless youth provide effective HIV and substance abuse prevention services to their clients. It addresses four basic questions:

- Who are runaway and homeless youth and how do they come to be out of the home?
- Why do programs that serve these youth need to understand and address HIV infection and the behaviors that elevate the risk of becoming infected?
- How can activities aimed at decreasing the risks of HIV infection and the abuse of alcohol and other drugs be integrated into the other services needed by runaway and homeless youth and their families?
- What types of administrative support are needed for these services to be effective?

Nowhere to Run is based on an extensive investigation into the most current research and the best programs concerned with runaway and homeless youth and the prevention of the abuse of alcohol and other drugs, unprotected sexual activity, and HIV infection among these youth.

A longer version of the review of the literature (summarized in Chapter 1), as well as more detailed information on this project's methodology, can be found in *The Runaway Risk Reduction Project Assessment Report* by Marc Posner.

Nowhere to Run is divided into two sections. Chapters 1 through 3 summarize what is known about runaway and homeless youth, the constellation of services these youth require if they are to reduce their risk behaviors, and the challenges of integrating HIV prevention activities into existing programs. Chapters 4 through 6 use a case study approach to describe a number of programs. Chapter 4 explores programs that serve the "street youth" of our larger cities. Chapter 5 describes two programs designed to provide short-term crisis intervention services, an effective and cost-effective strategy for addressing the needs of a large number of youth and their families. Chapter 6 focuses on the unique system of comprehensive care for runaway and homeless youth coordinated by the Division of Adolescent Medicine of the Childrens Hospital Los Angeles. While we do not claim that the programs described in this book are "the best" in the country, they are certainly among the best. We hope that the reader can learn as much from them through these descriptions as we did in our investigations of them.

CHAPTER 1

Researchers and practitioners generally divide runaway youth into three categories:

- runaway youth—those who leave home because of family conflict
- throwaway (or "thrownaway") youth—those who "have left home because their parents have encouraged them to leave, have abandoned them, or have subjected them to intolerable levels of abuse and neglect"[1]
- homeless youth—those who feel that they have no homes to return to, either because of irreconcilable conflicts with their family, because they have lost track of their family, or because their family is homeless

The youth who are the primary concern of most agencies that serve runaway and homeless youth, and will be the primary concern of this guidebook, are those who spend frequent and prolonged periods out of the home. The families of these youth are often characterized by conflict, the abuse of alcohol or other drugs, and sometimes physical and sexual abuse. These youth are sometimes referred to as "chronic runaways" (although it is possible that youth from severely dysfunctional families will run away only once or not at all) or "street kids" (although only a minority of them actually live on the streets or other open areas). This category also includes youth who are thrown out of their homes by their parents or guardians as well as youth who no longer have homes to which they can return. For lack of a better collective term, we shall refer to all these young people as "runaways." This is not to imply that the youth who leaves home for a night at a friend's home after an argument with his or her parents over grades or dating is not at risk of HIV infection. Public health practitioners generally agree that HIV prevention education, as well as activities concerned with prevention of the abuse of alcohol and other drugs, should be part of any comprehensive school health program (and that all schools should offer such programs). However, runaway youth face special challenges: challenges that elevate their risk of HIV infection and the abuse of alcohol and other drugs; challenges that make behaving in ways consistent with their physical and emotional well-being difficult; and challenges that complicate the delivery of effective prevention services to these youth.

Who Are The Runaways?

Estimates of the number of runaway youth in the United States range from 400,000 to 2 million. A recent nationwide study concluded that there were almost a half-million runaway and "thrownaway" youth in the United States.[2]

While runaways come from families of all income levels, a number of studies have found an overrepresentation of youth from lower-income families. Researchers and agencies report that the median age of the runaway population is about 15. However, most federally funded runaway programs (in which much of the data on runaways have been collected) exclude youth over the age of 18. Programs allowed to serve older youth and studies in which youth were interviewed on the street, rather than in shelters, report a higher average age. Older runaway and homeless youth are often faced with a predicament: they are excluded from many runaway programs, yet feel threatened or out of place at shelters for the adult homeless. The staff of shelters for the adult homeless also lack the training and resources to provide appropriate services to adolescents.

Studies reveal that female runaways outnumber males by as much as 10 percent. Some have suggested that this is because females are sexually abused in the home at a higher rate than males. Others maintain that the higher proportion of females is a reporting phenomenon, reflecting the following facts:

- Parents file missing child reports more often for females because they believe that females are in greater danger out of the home or that running away is more acceptable behavior for males.
- Police officers also tend to pay more attention to female runaways.
- Females tend to use emergency shelters more than males, and most data about runaways are collected in these shelters.

Programs also report that the gender ratio shifts in older age groups. Most homeless older adolescents are male.

Most research on runaways has been conducted in shelters in large cities. Little is known about runaways in rural areas. One government study concluded that youth run away from homes in urban and rural areas at nearly identical rates.[3] More research is needed on youth who run away from homes in rural areas, including where they live while out of the home and how they access social services in areas where the nearest emergency shelter may be miles away and public transportation is nonexistent.

Why Do Youth Run?

While young people run away from home for many reasons, family conflict is at the heart of most runaway episodes. An inability to communicate and resolve conflicts is characteristic of many families from which youth run (or are thrown out). Leaving home is often an escalation of a youth's response to a family in which he or she does not feel comfortable or wanted. In most cases, the responsibility for these conflicts cannot be placed simply on the child. Poor parenting skills and inability to communicate on the part of parents can also provoke or exacerbate family conflict. Many runaways have a history of risk behaviors, including substance abuse and acting out prior to leaving home. In many homes, patterns of conflict and risk behaviors are passed along from generation to generation. A large proportion of runaways report at least one of their parents has some sort of problem, including alcoholism, drug abuse, depression, attempted suicide, or a history of violence or criminal behavior.

A significant number of runaways are running, not just from emotional stress, but from physical danger. Between 60 and 75 percent report being seriously physically abused. Estimates of the percentage of runaway youth who are sexually abused while in the home range from 25 to 80 percent. The extent of physical and sexual abuse among runaways has led some researchers to call running away "a well-developed coping mechanism."[4]

A significant number of runaways are running, not just from emotional stress, but from physical danger.

Runaways who have been sexually abused tend to be more alienated from their families and are more likely to leave home permanently than other runaways. The emotional consequences of sexual abuse can lead to behavior that puts victims at risk of further sexual exploitation, unintended pregnancy, and HIV infection.

Some practitioners report that a not insignificant number of young people leave home because of conflicts with their parents, schools, and peers about their sexual orientation.[5] Most programs do not know how many gay, lesbian, and bisexual clients they serve because they do not ask and because gay, lesbian, and bisexual adolescents realize that disclosure of their sexuality may cause conflicts with other youth and program staff.

Leaving Home

Many practitioners and researchers maintain that running away is a mechanism used to cope with a family conflict: when the situation becomes intolerable, the youth leaves, allowing a "time-out" or "cooling-off period" before returning home. However, repeated runaway episodes can lead to the development of a "runaway career," and finally, to a loss of all ties to the family and home. With each runaway episode, the youth grows more adept at living out of the home[6] and parents tend to become less tolerant of "misbehavior" and less concerned about his or her absence. A youth may progress from being a "repeat runaway" (a youth who has left home more than once), to a "chronic runaway" (a youth who leaves home more often and for progressively longer periods of time) to a "street youth" (a youth who lives in a series of temporary living arrangements and spends much of his or her time living on the street, normally in a series of transitory residences including friends' apartments, cheap hotels, shelters, abandoned buildings, under highway overpasses, or in city parks). Finally, the youth loses the sense of having a family to which he or she can return and develops an identity of being "homeless."

Street youth sometimes come together in "alternative families" with other youth or older denizens of the street subculture. While many of these "families" are temporary and occasionally offer venues for adults to exploit youth (or youth to exploit one another), they also sometimes offer the kind of support and affection that was missing from the families and institutions from which these youth ran. Youth that have found such support within the street culture often find it hard to leave, despite the hardships and dangers that life on the street presents.

Youth who are wards of the court or involved with juvenile justice or child protection agencies are sometimes referred to as "systems kids." Systems kids share many characteristics with runaways including elevated risk for the abuse of alcohol and other drugs, conflict with parents, and physical and sexual abuse. Many have run away in the past (or will do so in the future). Whether a youth is identified as a "runaway" or a "systems kid" is often a function of whether he or she is placed in a shelter by the court or a child protective agency or is referred by the police, other youth, or outreach workers. Forty or 50 percent of runaways have spent time in foster care or group homes. A chilling footnote to this statistic is the finding by one study that 40 percent of street youth who have spent time in a foster home or other residential placement report that they have been assaulted, sexually abused, or otherwise physically victimized in that setting.[7] Such experiences add to a youth's mistrust of adults and social service agencies.

A smaller group of homeless youth are not "runaways" per se, but are members of homeless families who are living apart from their parents and siblings. Some of these youth separate from their families for economic reasons, much like their predecessors did during the Great Depression, and like their peers in many developing countries currently do. Others, particularly teenage boys from fatherless households, are left on their own when their mothers enter shelters that accept single mothers and their children, but not males over age 13. And, although this is not yet common, there has been speculation that more youth from the inner cities will be left alone and homeless as AIDS begins taking its toll among their parents and siblings.

Life Out of the Home

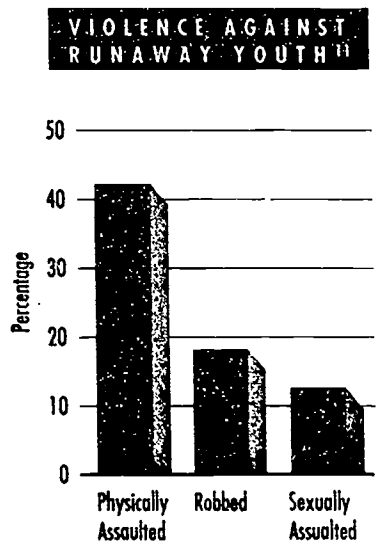
Most runaways do not run very far. More than half remain within 10 miles, and about 75 percent within 50 miles, of their homes. There are exceptions. Los Angeles, San Francisco, and Florida attract large numbers of runaways from other areas.

Runaway youth typically find shelter in a series of short-term living arrangements, including the homes of relatives, friends, or sexual partners; foster homes; and emergency shelters. While not without shelter, these young people are "homeless" in that none of these arrangements are stable or offer the social and emotional support of a family.

The runaway youth most often in the public eye, and those that provide the stereotype of runaways in the popular media, are the street youth who congregate in places such as New York City's Times Square or along Santa Monica Boulevard in Los Angeles. Although they represent a minority of runaway and homeless youth, they are the youth most likely to be engaged in prostitution and other high-risk sexual activities, to seriously abuse alcohol and other drugs, and to suffer the negative health consequences of being homeless. They also tend to be the most alienated of all runaways, lacking trust and being reluctant to use shelters and other services. While those runaways may not be literally sleeping on the street, they are probably spending a great deal of time there.

The health and psychological consequences of "life on the street" often compound the medical and emotional problems resulting from abuse and neglect at home. One researcher wrote that "there is no aspect of homelessness that does not imperil physical health or complicate the delivery of adequate health services."[8] Poor nutrition, inadequate sleep, and exposure to the elements result in a host of medical problems. A survey of the health status of runaways in shelters found that 80 percent had one or more of the following medical problems: general illness (fever, chills, vomiting, diarrhea, or sore throat); trauma; sensory dysfunction (such as blurred vision); headaches, nausea, stomachaches, or abdominal pain; gynecological problems; or dental problems.[9] Sexually transmitted diseases (STDs) are also prevalent among this population. While the primary concern of this document is HIV infection, syphilis, hepatitis, and chlamydia and other STDs can have severe and life-long consequences if not detected and treated in their early stages.

Violence also presents a danger to the health of runaway youth. One study found that 42 percent of its sample reported being assaulted, more than 18 percent reported being robbed, and 12.5 percent sexually assaulted during the previous 12 months.[10] Rape rates were found to be especially high among female runaways and runaways of both sexes who were involved in prostitution.



The high level of psychological disorders found among runaway youth is not surprising given the reasons they left home, the conditions under which they live once out of the home, and their lack of familial support and other social bonds. Runaways tend to have low self-esteem and a negative self-image. One study found the rates of major depression, conduct disorder, and post-traumatic stress syndrome to be three times as high among runaways as among youth who had not run away.[12] A significant proportion of runaways have attempted suicide or are actively or potentially suicidal. This is especially true of runaway youth who are gay, lesbian, or bisexual: they are three times as likely to attempt suicide as their heterosexual counterparts.[13]

Runaways who have been abused are at even greater risk of serious psychological disturbances. Emotional, physical, and sexual abuse can lead to aggression, depression, low self-esteem, anxiety, suicidal feelings, substance abuse, post-traumatic stress syndrome, multiple personality disorder, academic performance difficulties, sleeping disorders, and self-destructive behavior, as well as increased distrust, both of adults and other adolescents. A lack of familial, peer, and institutional supports and bonds can only intensify these problems.

The abuse of alcohol and other drugs often pervades a runaway's life, both in and out of the home. Runaways are far more likely to abuse alcohol and/or other drugs than youth of a similar age who have not run away.[14] Runaways who use drugs and alcohol tend to do so frequently and abuse a variety of substances. Many practitioners claim that the only way runaways can face their dismal life (especially if they are engaged in prostitution or exchange sex for drugs or a place to spend the night) is by blurring their consciousness with alcohol or illicit drugs. Drugs and alcohol are also used to cope with the emotional consequences of child sexual abuse. Some youth workers refer to such substance abuse as "self-medication."

At least three-quarters of runaways are sexually active. In part, this reflects the level of sexual activity among contemporary adolescents. However, there are additional factors that may impel runaways to engage in high-risk sexual activity. Runaway adolescents are unsupervised at a point in their lives when they are attempting to come to terms with their sexuality. Runaways often feel, and many actually are, rejected by their parents. Many have been victimized or neglected by those who were supposed to love and nurture them. Once out of the home, they often pay for "acceptance and love with their bodies."[15] Many youth, especially those who have been sexually abused, have no understanding of the difference between intimacy and sexual intercourse.

Some runaways informally exchange sex for food, drugs, a place to stay, or the protection of someone older or stronger than themselves. They usually do not perceive such an exchange as prostitution or as even being an exchange. Such behavior is generally referred to by practitioners (but not by the youth) as "survival sex." Rural areas often lack emergency shelters, abandoned buildings, and parks in which runaway youth can live and avoid the attention of the police.

Runaway girls in these areas often move in with older men as a way of escaping from family conflict or an abusive home. This may also be true of adolescent gay males. All of these behaviors elevate a youth's risk of becoming infected with HIV.

Estimates of the percentage of runaways who explictly engage in prostitution range from 11 to 25 percent. This percentage increases dramatically in some urban areas, notably Los Angeles and New York City, where rates of 26 percent to 35 percent were found. Seventy percent of street youth in New York City admitted prostituting themselves.[16] Practitioners report that the explicit exchange of sex for drugs, food, or a place to stay is on the increase among runaway and homeless youth. The sexual partners involved in these transactions are often older men who may be injectable drug users or have multiple sexual partners (including prostitutes).

While only a minority of runaways turn to prostitution, most youth who become involved in prostitution do so as runaways. These youth are often products of single-parent families or reconstituted households in which the abuse of alcohol and other drugs, neglect, and ineffective parenting are present. Youth who were sexually abused at home are those most likely to turn to prostitution.

> Experiences of rape, molestation, and incest, common among young prostitutes, result in a lessened sense of sexual self-respect and of control over one's body. Adolescents are often not believed when they report sexual abuse. They are often blamed and internalize responsibility for their involvement. This results in further emotional trauma and negative self-labeling. Feeling different from their peers, they may begin to withdraw socially. Once sexually abused, the young person's ability to prevent further exploitation is eroded. In this manner, they are prepared for entrance into prostitution.[17]

Long-Term Consequences of Running Away

In past decades youth who left home had at least a marginally acceptable social role to fill. They could immigrate to the New World. They could find employment as an apprentice, go to sea, or join the military. While life in a 18th century merchant ship or in a 19th century factory may have been brutal, it did provide young people with a legitimate means of earning a living. Today's runaway youth, while having plenty to run from, have little to run to. One study put it this way:

> Unlike the youth who ran away from home during the 19th and early 20th centuries, who had a relatively easy time integrating into the community and securing work roles, today's youth face greater difficulties finding a place for themselves in the economic structure. The prolonged period of adolescence as a moratorium from adult responsibilities, such as work, has destroyed many of the legitimate economic roles into which young people could once fit. In order to survive, increasing numbers of street youth see no alternative but illegitimate economic activities, e.g., prostitution, robbery, the drug trade.[18]

It is difficult for a teenager without a permanent address, and who may be obviously sick and/or in need of a shower and a change of clothes, to find employment. However, because they are not being supported by their parents, they are in need of money. Some panhandle. Some turn to crime. In addition to prostitution and dealing drugs, many steal and shoplift. It is no surprise that these activities (as well as the violence that is a large part of life on the streets) often bring runaways into contact with the police. And it is no surprise that the life of runaways in no way prepares these youth for life as self-supporting adults.

Little research exists on the long-term effects of running away. One study compared adults who had run away as adolescents with their siblings and found the ex-runaways to have higher levels of school incompletion, unemployment, job dissatisfaction, debt, marital conflict, psychological problems, and arrests. Individuals who had run away on several occasions tended to have more (and deeper) problems than those who had left home only once.[19]

Given their history, adults who spent extended periods out of the home as children and adolescents are likely to have difficulty parenting, because physical and child abuse, poverty, academic failure, and teenage pregnancy often emerge in succeeding generations of the same families. Extended periods spent living out of the home and in transitional situations such as emergency shelters, foster homes, and juvenile detention centers have a detrimental effect on a youth's emotional and social development. And, in the age of HIV, even a short period spent in a high-risk environment can have fatal consequences.

NOTES

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[17] Deisher, Robinson, and Boyer. "The adolescent female and male prostitute."

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CHAPTER 2

Runaway and homeless youth have been said to represent the "next wave" of HIV infection.[1] While little hard data are available, some practitioners estimate that 10 to 20 percent of the street youth in New York City are infected with HIV.[2] HIV infection is often not discovered until it develops into AIDS, a process that can take 10 years. Many (if not most) of the teenagers who are infected with HIV do not develop AIDS until they are in their twenties or early thirties.

Very few runaway youth use any form of protection during sex. This can have dire consequences.

- Research has found that runaways have much higher rates of sexually transmitted diseases than other young people. Because of the absence of regular medical care, many runaways are never treated for these diseases.
- Many runaways who are treated for STDs later return for additional treatment, indicating that they have not reduced their high-risk behaviors.
- An extremely high percentage of female chronic runaways become pregnant.

Those runaway and homeless youth who engage in prostitution or survival sex are putting themselves at increased risk of HIV infection. Prostitution generally involves multiple partners, some of whom may be injectable-drug users. Youth involved in prostitution are often reluctant to use condoms or avoid high-risk sexual activities (such as anal intercourse) for fear of losing their clients.

Alcohol and other drugs act as disinhibitors and affect judgment. Youth who are drunk or drugged may be more prone to engage in sex or in unprotected sex than other youth. Negotiating the use of a condom or low-risk sexual activities is hard enough for an adolescent. When the adolescent is drunk or drugged, it becomes more difficult. Many in the field predict that crack use will contribute to an increase in AIDS and other STDs because it often leads to prostitution and bartering sex for drugs.[3] And, although only a minority of runaways use injectable drugs, those who do are putting themselves at direct risk of contracting HIV through sharing needles.

It is a mistake to think of HIV as a problem limited to large urban areas. Centers for Disease Control statistics reveal that nearly a third of AIDS cases among teenagers occur outside of metropolitan areas that have populations of a half-million or more. And as of 1992, 49 states (and the District of Columbia) had reported cases of AIDS in people between the ages of 20 and 24, with 44 states reporting cases of AIDS in teenagers.[4]

An increase in the number of runaways who are HIV infected or develop AIDS will certainly have a profound impact on runaway programs. The placement of children with AIDS raises a number of medical, emotional, and institutional problems.[5] An increase in the number of HIV-infected runaway youth may make placement and family reunification even more difficult.

HIV Prevention For Runaway And Homeless Youth

Adolescents can be especially hard to convince to take precautions against HIV infection because they

- lack a future orientation and thus have difficulty believing that their actions can have tragic consequences years later
- often do not want to listen to what adults and authority figures have to say
- are coming to terms with their sexuality and often mature physically much sooner than they mature emotionally and cognitively

Helping runaway and homeless youth make effective behavioral changes in their lives is further complicated by the context in which HIV prevention education takes place.

- Such education must often take place in an extremely short period of time—a five- to fourteen-day stay in an emergency shelter, a one-hour counseling session, or a five- to ten-minute conversation on the street.
- Much of the material available for HIV prevention was created for classroom use and assumes that its audience will be able to attend a number of structured sessions. This assumption is not appropriate for programs in which youth enter and leave as individuals rather than as cohorts.
- Much of the material available for HIV prevention sets goals that are unrealistic for the adolescents at greatest risk.
- Youth in outreach or drop-in settings, or in a program for a short time, do not receive reinforcement of the messages and are more than likely exposed to negative pressure from their situations and their peers, which contradicts HIV prevention messages.

Runaway youth often lack familial bonds, and have few positive adult role models. Their disconnection can prolong adolescence well into the twenties. The exclusion of runaway youth over 18 from many programs is problematic. Their experiences with parents, social service staff, and their contact with the adults who dominate the street subculture also increase their distrust of adults. Experiences with incest, sexual abuse, survival sex, and prostitution have devastating consequences for their sexual identities. Their lack of a future orientation is heightened by the understandable fact that many of them have no foreseeable future. Trudee Able-Peterson, who works with street youth in the Times Square area of New York, wrote:

> It is hard for these kids to think about preventing diseases that will strike them in three, four, five years. . . . The kids I see ask me, how can I worry about something that will kill me in five years when I don't know if I am going to be alive in the morning? You know, getting in the wrong car with the wrong trick, taking drugs.

The risk of HIV infection is reduced by reducing or eliminating certain behaviors including unprotected sexual activity (which often is a consequence of engaging in sexual activity while under the influence of drugs or alcohol) and sharing needles used for injecting drugs, tattooing, or body-piercing. The most effective way of reducing these behaviors coincides with the ultimate goal of services for runaway and homeless youth: removing the youth from a high-risk environment (that is, an environment where elements exist that impel a youth to engage in high-risk behaviors) and/or helping youth develop the decision-making, communication, and technical skills necessary to reduce risk in any environment. Removing a youth from a high-risk environment can include:

- providing youth with alternatives to street life, including family reunification or transitional living programs
- removing a youth from a dysfunctional family situation
- working with a family to create a more supportive family situation (one in which sexual, physical, and substance abuse are not present, and in which family conflict is resolved through negotiation rather than argument and/or violence)

Assisting a youth in making the transition from homelessness to a more stable environment, be it the family, foster care or a group home, or an independent living situation, is often a slow and difficult process. It is also important to help youth develop skills that will help protect them against HIV infection while they are living in environments in which this risk is substantial. These skills include:

- problem-solving, decision-making, communication, and social skills that assist youth to make healthy decisions about their behavior and their health
- methods of reducing the risk of HIV infection for those youth who are sexually active (such as negotiating the use of condoms with their sexual partners or noninsertive sexual behaviors)

Activities for the prevention of HIV infection can be, and should be, included at every opportunity and at every level of the services appropriate for runaway and homeless youth.

Comprehensive Services for Runaway and Homeless Youth

The comprehensive services needed by runaway and homeless youth, and their families, can be broken down into four levels: outreach, crisis intervention, stabilization, and long-term/support/aftercare services. Each of these levels includes services that try to reduce the risks of being out of the home. While there are limits to the risk reduction possible in each of these stages, the irreversibility and lethality of HIV infection mandate that HIV prevention activities (including those directed at the prevention or reduction of abuse of alcohol and other drugs) be incorporated at all levels of service.

Outreach Services

Runaways are often reluctant to make use of the services offered by shelters and drop-in centers. Many have had negative experiences with their parents, other adults, and social service and law enforcement agencies. Thus, many agencies must actively seek out runaway and homeless youth on the streets. Outreach generally involves teams from one or more agencies that mingle with runaway and homeless youth in areas in which youths congregate, and attempt to engage them in conversation, build trust, and encourage them to develop more consistent contact with service providers.

In the age of AIDS, street outreach takes on a new importance.

The HIV epidemic has brought about two changes in the nature of outreach activities. Outreach activities have traditionally been based on taking time to build trust with a runaway or homeless youth. But the threat of HIV infection has spurred outreach workers to place greater emphasis on immediate HIV prevention aspects of their contacts. This includes talking to youth about the relationship among the abuse of alcohol and other drugs, unprotected sexual activity, and HIV. In many cases, outreach workers also provide condoms and teach youth how to use them and how to negotiate this use with their sexual partners. Some programs also provide injectable-drug users with free bleach and instructions on how to clean needles, syringes, and other paraphernalia.

The increased dangers of street life have also prompted many programs to engage in outreach efforts to prevent youth from running away. Programs send educators (often peer educators and/or former runaways) into schools and community youth organizations to talk about the dangers of life on the street and alternatives to running away from home (including "running" to a youth-serving agency rather than spending even one night on the streets). Since many runaways, future runaways, and other youth become involved in high-risk activity while still in the home, many of these programs also emphasize the dangers of the abuse of alcohol and other drugs, unprotected sexual activity, and their relationship to HIV infection.

Crisis Intervention Services

Crisis intervention services include counseling, medical care, food, and shelter. They provide safety from the streets or time-out for a youth who is having problems at home. In some agencies (especially those specializing in short-term intervention), crisis intervention services are not always distinguishable from stabilization services. Crisis intervention services seek to limit the abuse of alcohol and other drugs, as well as high-risk sexual activities, by removing youth from an environment in which these behaviors are tolerated. Many runaway youth run away again or continue to have unprotected sex while living at home or in institutional placements. Thus, youth involved in crisis intervention services need to be provided with the knowledge and skills needed to reduce their risk of HIV infection. Such knowledge and skills can be provided during individual or group counseling, special educational groups on HIV and AIDS, or the identification of youth at greatest risk of HIV infection for specialized services (including testing, counseling, and education).

Stabilization Services

Stabilization services help runaway youth build emotional and physical security, preparing them to make plans for the future. These services include assessment, counseling, group counseling, and family counseling to help the youth and the family decide whether the youth should return home, and under what conditions. For street youth, stabilization also includes adjustment to a predictable environment in which they are expected to follow rules, maintain a schedule, and treat themselves and others with respect.

An important part of stabilization is coming to terms with the abuse of alcohol and other drugs, since such abuse often interferes with attempts to find long-term solutions to a youth's situation. Youth (and often their families) often receive education about the dangers and prevention of HIV infection, the abuse of alcohol or other drugs, and unprotected sexual behavior. The stabilization normally includes a long-term plan for the youth's future and living situation.

Long-Term Support and Aftercare Services

Long-term support and aftercare services assist a youth to reintegrate into society. Services may be directed at reuniting the youth and his or her family; placing the youth with a different parent, relative, or friend; involvement in a transitional or independent living program; or placement in foster care or a group home. Normally, a long-term institutional placement implies that the facility in which a youth is placed (or the agency overseeing that facility) will assume case management and service provision responsibilities. However, agencies for runaway and homeless youth will often provide aftercare and support services to youth who return to their families or enter transitional living programs. These services include counseling, family counseling, outpatient drug treatment, support groups, and vocational and educational services.

Continued emphasis on preventing the abuse of alcohol and other drugs and unprotected sexual behavior is needed for most youth during this process. Youth who have been alcohol- or drug-dependent often need continued support to remain sober or drug free (which often includes participation in 12 Step or other support programs). Survivors of sexual abuse also need specialized support services.

The growing number of runaway and homeless youth who are infected with HIV require specialized psychological and medical support services including support groups, counseling, inpatient and outpatient medical services, and hospice care.

This level of care is usually extremely expensive. The financial and programmatic impact of these services alone—not to mention the human tragedy—would warrant HIV prevention services among this population.

The integration of new services and components to meet the threat of HIV is often difficult for programs that are generally underfunded and understaffed, and whose staffs are already underpaid, overworked, and subject to professional burnout. The next chapter discusses integrating HIV prevention activities into existing programs.

NOTES

1 Kearnon. "Deinstitutionalization, street children, and the coming AIDS epidemic in the adolescent population."

2 Kolata. "AIDS is spreading among teen-agers, a new trend alarming to experts;" Stricof, Kennedy, Nattell, Weisfuse, and Novick. "HIV seroprevalence in a facility for runaway and homeless adolescents;" Testimony of Ronald Williams, Subcommittee on Human Resources.

3 Fullilove, et al. "Risk of sexually transmitted disease among Black adolescent crack users in Oakland and San Francisco, California."

4 Select Committee on Children, Youth, and Family, United States House of Representatives. *A Decade of Denial: Teens and AIDS in America.*

5 Rotheram-Borus and Koopman. "Research on AIDS prevention among runaways: The state of the art and recommendations for the future."

CHAPTER 3

Program Planning for HIV Prevention

To be effective, HIV prevention activities cannot be isolated, but must be integrated into virtually every aspect of an existing program, from policy development to staff training to street outreach. Every staff member and every client should be affected.

Such integration presents unique challenges to administrators and program managers. HIV prevention involves raising sensitive issues about sexuality; the abuse of alcohol and other drugs; illness; and death—issues that both clients and staff often would rather not confront. HIV prevention activities, and especially HIV antibody testing, raise the possibility that the program and its staff will have to face clients who are infected with HIV, have AIDS, or are dying. The emotional, programmatic, and financial ramifications can be enormous.

When adding HIV prevention to a program's agenda, managers need to consider not only the addition of a new program component or components (such as HIV education sessions), but also a range of changes:

- providing consistent, accurate, and explicit HIV prevention messages in virtually every program component that involves client interaction
- formulating and adopting written HIV policies
- conducting training on HIV, AIDS, and HIV prevention, not merely for staff members who are primarily engaged in HIV prevention, but for everyone connected with the program, including volunteers, peer youth leaders, and members of the board of directors
- confronting the implications that having clients or staff who are HIV infected or who have AIDS will have for a program, including the effects on staff and other clients, the necessity to provide or access medical care for such individuals, and the complications this may have for family reunification or alternative placement

HIV prevention must also reflect the principles that characterize all sound programming, including articulated goals and objectives, defined policies and procedures, assessment of the evolving needs of youth and the program, informed design and implementation of prevention activities, staff training and support, and evaluation. The threat of HIV, and a program's response to that threat, have implications for each of these elements. These implications are the focus of this chapter.

Establishing Goals And Objectives

Many agencies for runaway and homeless youth have a written mission statement articulating the agency's basic philosophy, goals, and commitments. A similar mission statement about HIV may help instill in the staff a sense that HIV prevention is a response to a life-threatening disease, and that this response, if not effective, may undo all their good work. Such a mission statement might include statements concerning:

- the ultimate goal of lowering the risk of HIV infection among the agency's clientele
- the programmatic goal of integrating HIV prevention into all components of the agency and/or providing specific HIV prevention activities
- a reminder that HIV is a threat everywhere and to everyone and should not be taken lightly, even in areas with low incidence

Once an agency has decided to implement HIV prevention activities (or systematically improve its capability in this area), it needs to develop specific short- and long-term objectives. Long-term objectives might include the following:

- educating every staff member from administrators to support staff about HIV prevention and the agency's HIV policies
- assessing the HIV risk of every youth who goes through the program's intake procedure
- making certain that every client in the program receives multiple opportunities for HIV prevention education
- including HIV prevention messages in every program component from outreach to aftercare

Short-term objectives might include:

- creating, improving, or reinforcing HIV awareness among the staff, volunteers, management, and board of directors
- identifying resources to be used in implementing or upgrading HIV prevention activities
- designating some staff as HIV specialists to be given additional specialized training
- reviewing and updating existing HIV policies, or creating such policies if they do not already exist

Developing Policies and Procedures

The importance of clearly written policies and procedures can not be underestimated. Clear policies let staff, management, and clients know what the agency expects of them and what they can expect from the agency. Policies also provide guidance for handling difficult situations and guard against staff and volunteers behaving in ways that are inconsistent with the agency's philosophy and goals.

Some programs that serve runaway and homeless youth have developed written policies on a number of HIV-related issues, including HIV education for staff and youth, HIV antibody testing, privacy and confidentiality concerning HIV status, and nondiscrimination against staff and youth who are seropositive.

Policies for preventing occupational exposure to HIV should include:

- explicit precautions about sharing of razors, toothbrushes, and ear-piercing and tattooing equipment
- directions for handling bodily fluid spills that are consistent with the Centers for Disease Control guidelines and the regulations promulgated by the Occupational Safety and Health Administration

Policies for educating staff and youth about HIV and AIDS should include:

- a statement about the agency's belief that HIV prevention education is necessary
- attendance expectations for youth and staff at training and support sessions that deal with HIV and AIDS
- a record-keeping system that allows the agency to keep track of which clients and staff members have received HIV training and which have not
- explicit nondiscrimination policies covering clients and staff who have been infected with HIV

If an agency offers HIV antibody testing or helps clients gain access to such testing, it needs to have policies that address the following:

- the role of testing as a medical/diagnostic tool
- the provision of adolescent-appropriate pre- and post-test counseling and assisting clients with their decision about whether to be tested

- training for those who will engage in such counseling, including special training in adolescent development, suicide assessment, and prevention
- the procedure for revealing test results to clients
- obtaining written informal consent for testing from clients
- issues of confidentiality—who else within or outside of the agency will be informed of the client's HIV status and under what circumstances?
- the provision of medical and psychological services to clients who are infected

Agencies that do not provide access to HIV antibody testing also will face questions concerning HIV status and confidentiality: Who will be told that a youth or employee is HIV positive, and under what circumstances? What type of written records concerning HIV status will be kept?

Agencies need to become familiar with their state laws on confidentiality before creating such policies. Some states have strict laws governing the disclosure of HIV status.

All agencies also should have written policies concerning discrimination against people who are infected with HIV. These policies should state the availability of services to HIV-infected youth and staff. Agencies should formulate these policies *before* such issues arise.

Investing in policy development can avert crises before they occur. This is especially important in environments such as runaway programs that attempt to offer alternative models to the chaotic and crisis-oriented patterns to which youth have been exposed in their homes and on the streets.

Assessing Needs

While most runaway and homeless youth are, to some degree, at risk of becoming infected with HIV, the level of this risk will vary from youth to youth and (in general) from program to program. A rural Midwestern program may not need the same HIV components as do programs in larger urban areas. Nonetheless, *all* programs should include some HIV prevention activities.

Agencies preparing to implement or improve HIV prevention activities need to ask themselves how much they really know about their clients. The risk of HIV infection results from behaviors that clients and staff may be uncomfortable discussing

(e.g., the abuse of alcohol and other drugs and unprotected sexual behavior). This discomfort may diminish an agency's willingness and effectiveness to meet its clients' needs for HIV prevention.

Assessment of client needs can take two forms. Most agencies have some sort of individual assessment mechanism in place. Agencies should evaluate this mechanism to see if it includes assessment of a youth's risk for HIV (including the youth's involvement in unprotected sexual behaviors, knowledge, or lack of knowledge about HIV, and desire to learn more about HIV and HIV prevention). Tools for such assessment are available as part of many of the materials listed in the Resources section.

Agencies also need to know as much as they can about their clients, the factors that may put them at risk of HIV, and the factors that impact upon the way in which HIV prevention activities need to be presented in the program. Program staff often know a great deal about their clientele, although they may need help in applying this knowledge to HIV prevention activities. Unfortunately, many runaway programs fall victim to some common "myths" about their clients, which affect their motivation and ability to provide HIV prevention services.

MYTHS

None of the youth served by our agency are gay, lesbian, or bisexual.

The youth in our agency do not use drugs or, if they do, they do not use injectable drugs.

The youth in our area are not involved in prostitution.

It is only youth who are gay, injectable drug users, or prostitutes who are at risk of becoming infected with HIV.

Myth Number One

None of the youth served by our agency are gay, lesbian, or bisexual. Gay men and lesbians are subject to discrimination, ostracism, harassment, and physical violence. Many gay, lesbian, and bisexual youth will not reveal their sexual orientation, even to the most sensitive of program staff because of fear of what might happen if this information becomes known to others in the program, schools, community, or families.

One of the developmental tasks of adolescence is coming to terms with one's sexual identity. Many adolescents who will identify themselves as gay or lesbian as adults have not yet firmly established this identity as adolescents. And many adolescents who will not identify themselves as gay in the future may experiment with same-sex sexual activity in their youth (either as part of coming to terms with their sexuality or as a survival mechanism when out of the home). Programs must make sure that their HIV education, and their counseling and interaction with clients in general, are inclusive and respond to a diversity of sexual identities and behaviors.

Programs need to offer support for gay and lesbian youth. Such support should include explicit nondiscrimination policies that guarantee a safe climate for gay and lesbian youth in the program. Programs must maintain a safe and nonviolent climate by not tolerating any physical or verbal harassment of its gay and lesbian clients (nor any harassment based on gender, race, religion, or ethnic identity).

Even in a secure climate, gay and lesbian youth are often reluctant to be open about their sexual orientation. Many are still coming to terms with their sexual identity and have yet to accept or decide if they are gay, lesbian, or bisexual. Most are aware that, no matter how secure a program may be, open disclosure of their sexual orientation may cause problems for them when they are back in their homes, schools, or out on the street. Practitioners warn against identifying clients as gay or lesbian unless they themselves choose this identification. In addition to a public climate of acceptance, agencies need to let gay and lesbian clients know that their sexual orientation will be respected and (if they wish) concealed from others. The presence of open gay and lesbian individuals on a program's staff can have a tremendous impact upon gay and lesbian youth in a program. It also helps create a climate of nondiscrimination by providing a public focus to discuss issues of sexuality without having to identify the sexual orientation of individual clients.

Myth Number Two

The youth in our agency do not use drugs or, if they do, they do not use injectable drugs.

The majority of adolescents experiment with illicit drugs or alcohol. A significant percentage of high-risk sexual activity takes place under the influence of alcohol or other drugs. Therefore, youth must learn that their behaviors concerning the use of intoxicating substances, including alcohol, ultimately have consequences for their sexual behavior. Even the best intentions not to have sex, or to practice safe sex, can be overwhelmed by the disinhibition or the impaired rationality caused by

intoxication. At the same time, agencies must be careful not to equate risk with blame and reinforce the low self-esteem of many of their clients. After all, this low self-esteem puts many youth at risk in the first place.

Myth Number Three

The youth in our area are not involved in prostitution. Prostitution, like abuse of alcohol or other drugs, is not restricted to large cities. It takes many forms and occurs in every part of the country. Suburban and rural communities may not have a "strip" in which young men and women offer themselves to passersby. Prostitution in these communities may be underground and invisible. Young people may be trading sex for food, drugs, or a place to stay. Although they may not think of this as prostitution, it is a high-risk behavior that can lead to HIV infection.

Myth Number Four

It is only youth who are gay, injectable drug users, or prostitutes who are at risk of becoming infected with HIV. All sexually active youth are a some risk of becoming infected with HIV. And a large percentage of American adolescents are sexually active.Programs that deny this reality are doing their clients and their community a grave disservice.

Designing HIV Prevention Activities

Activities for the prevention of HIV can be integrated into programs for runaway and homeless youth in a number of ways, including the following:

- HIV education during street outreach
- HIV risk assessment during intake (focusing on behavior)
- specialized experientially-based groups (including interactive role-play and skill-development activities) on HIV, the abuse of alcohol or other drugs, and unprotected sexual behavior
- raising HIV concerns in counseling and case management activities with individual clients
- use of HIV prevention videos
- peer-led HIV education
- the inclusion of HIV content in other educational contexts, such as those involving sexuality, the abuse of alcohol or other drugs, or health education and wellness, or in groups for specific audiences (which often have specific HIV-related risks) including young women, gay, lesbian, or bisexual youth, victims of sexual abuse, youth involved in prostitution or survival sex, drug or alcohol abuse treatment groups, and groups for pregnant and parenting teens

An assessment should be conducted of what mechanisms already exist that can serve as conduits for HIV prevention messages. Some programs may not need to implement specific HIV prevention activities, but rather to integrate HIV content into existing activities concerned with wellness, the abuse of alcohol or other drugs, or sexuality. Other programs may want to develop specific program components targeted at HIV and use other venues to reinforce HIV prevention messages.

Integrating HIV prevention activities into an agency need not be overly expensive. But it is never free. Minimally, some training will be necessary. Agencies may have to raise new funds for such activities. Many governmental and private sources can be approached to fund HIV prevention activities.

Other sources of funds that can be used for HIV prevention activities include monies targeted at:

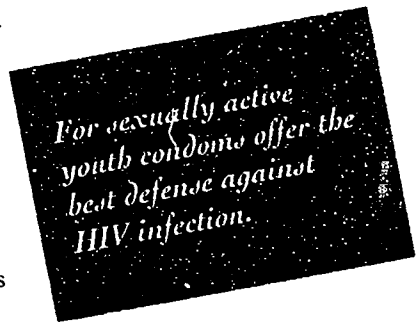
- substance abuse prevention and treatment
- pregnancy prevention
- health or sexuality education
- other STD prevention
- counseling for victims of sexual abuse or exploitation

All of these services can, and should, contain some content explicitly aimed at HIV prevention. A number of agencies can join to sponsor cotraining, which may reduce its cost.

Distributing Condoms

The distribution of condoms to adolescents is still a controversial issue in many communities. Opponents claim that providing teenagers with condoms implies that there is nothing wrong with adolescents engaging in sex and may even inspire those who have not become sexually active to do so. Proponents claim that there is no evidence that condom distribution promotes sexual activity among teenagers, that all evidence shows that the majority of teenagers are, in fact, sexually active, and that the importance of preventing infection with a virus for which there is no known cure far outweighs any concerns about the ultimate appropriateness of teenage sexuality.

As has already been discussed, runaway youth (and especially chronic runaway and homeless youth) are at high risk of becoming infected with HIV. Condoms can help reduce this risk, as well as that of other sexually transmitted diseases and unintended pregnancy. Programs offer condoms in many ways. Some programs target condom distribution at chronic runaways and homeless youth during street outreach efforts. Others leave condoms in baskets around their drop-in centers so that youth can take them without having to go through the embarrassment of asking. Some programs leave bowls of condoms on the shelves in their bathrooms so that adolescents can take condoms in complete privacy. Multiservice agencies that also might be serving very young children suggest placing bowls of condoms at a height accessible to teenagers, but above the view of very young children who may be using the same facilities.



However, merely providing condoms to clients does not ensure their proper or consistent use. Some adolescents do not realize that an HIV infected person may look (and feel) perfectly healthy. Others do not have the skill needed to negotiate using condoms with their partners. Those engaged in prostitution or survival sex are often afraid to insist on using condoms for fear that this insistence will cost them a trick, a meal, or a place to stay. Others use condoms with their clients, but not with their "boyfriends" or "girlfriends." Thus, while condoms are an important tool in the fight to reduce the spread of HIV, they need to be distributed in the context of an HIV prevention program so that youth can learn why and how to use them. In particular, condom education must include:

- information on the importance of correct and consistent condom use
- instruction in those skills necessary to negotiate condom use with sexual partner

It is especially important for youth to receive this instruction in safe, nonsexual environments. Convincing sexually active youth that condoms should be used at every opportunity not only reduces their risk of becoming infected with HIV, but can provide an additional motivation for them to increase their contact with outreach workers or come into a drop-in center when they need to replenish their supply.

Educating Staff and Volunteers

Implementing an HIV prevention program has implications for runaway program staff, to whom HIV prevention may be a new concept. HIV prevention involves talking with youth about issues that may make staff and their clients uncomfortable: sexual behavior, sexual identity, and death. Staff development activities are a prerequisite for effective HIV prevention activities. If staff and volunteers lack information about HIV or are uncomfortable talking about it, an HIV prevention program will not be effective. This applies to all the staff, not just those explicitly involved in HIV education. Every member of the staff, including volunteers, must be prepared to comfortably confront this issue and answer questions about HIV that may arise in their interactions with youth. The issue of homophobia among the staff must also be explicitly addressed if a program is going to be able to effectively serve youth at risk of HIV.

Administrators must also be informed about HIV and its prevention. They need to understand the problems that line staff face in implementing HIV prevention activities. They are responsible for promoting the policies, training, and institutional support necessary for effective HIV prevention. Even those administrators who do not have direct service responsibilities should be educated about HIV and its prevention.

There are a number of ways to bring staff and volunteers the knowledge, skills, and sensitivity they will need to effectively meet the challenge of HIV. A number of "off-the-shelf" curriculum and training guides are available. Several organizations offer HIV prevention staff training. Some offer "training-of-trainers" sessions in which one person from an agency is trained to bring information back and share it with the rest of the staff in effective ways.

There are advantages and disadvantages to all these models. Off-the-shelf materials (including manuals, discussion guides, and videos) are the least expensive way of bringing a staff up to speed on HIV. They also are probably the least effective (at least in providing those skills necessary to change the implicit knowledge, attitudes, and behavior of the client population). While providing direct training for the staff is probably the most effective method, it is also the most expensive. Sending one or two staff members to a training-of-trainers session may cost less.

However, staff sent to such a training must be able to conduct professional education sessions for their colleagues and must receive institutional support (such as release time from other duties to prepare and conduct sessions) if this process is going to be effective. Those responsible for training staff about HIV should be given ongoing support.

HIV education for staff, as for clients, cannot be a one-time event. Staff need time to absorb new information and practice new skills. Use of these skills with the clients will probably raise additional questions and concerns. HIV education for the staff, as well as for the clients, must be an ongoing activity. It is important that new staff be trained in HIV prevention as soon as possible. The medical and social research on HIV is constantly changing. New information about risk behaviors, symptoms, testing, and therapies needs to be tracked and disseminated to other staff members.

Unfortunately, the necessity of confronting an emotionally charged issue such as HIV may contribute to the pressures toward burnout that exist in human service agencies. This is especially true in agencies that serve youth who are known to be infected with HIV or show symptoms of AIDS or HIV-related diseases. One way of combating this problem is by providing structured mandatory support group meetings, especially for those staff who counsel youth around issues related to HIV. Such sessions should be facilitated by a professional and should address topics such as working with youth who are at risk for HIV and who continue high-risk behaviors, counseling youth who want to be tested, and working with youth who have been tested and diagnosed as seropositive.

Evaluating HIV Prevention Activities

Most programs for runaway and homeless youth are inadequately funded and understaffed. Evaluation frequently takes a back seat to more immediate and pressing concerns. Evaluation, however, has many benefits, not the least of which is improved services for youth.

Why Collect Data and Evaluate Programs?

Data collection and evaluation are useful for several reasons. They can do the following:

- determine how well HIV prevention activities are working and which areas need improvement

- provide staff, administrators, and board members with documentation that HIV prevention efforts *are* making a difference, even though it may not always seem that way
- offer evidence that the agency is meeting its stated goals
- formalize a process that builds in time for staff to reflect, synthesize and analyze, and gain perspective
- help with systematic planning and assessment of the evolving needs of youth, families, staff, and the community
- demonstrate to current and future funders that the agency offers effective services

How Does an Agency Collect Data and Evaluate Its Programs?

There are two basic types of program evaluation: process and outcome.

Process evaluation examines how well an agency has met its programmatic objectives. It attempts to answer questions such as:

- How many members of the staff have received training in HIV prevention?
- What proportion of clients attend at least one HIV prevention session?

An outcome evaluation measures the progress made toward achieving the program's final goals, which may be:

- increasing staff knowledge of HIV infection and risk reduction
- reducing the risk of HIV among its client population

Most agencies will not be able to determine how many of their clients become infected with HIV (and whether this infection occurred before, during, or after their participation in the program). However, some proxy measures are possible, including those measuring knowledge, attitudes, skills, and behaviors. How much time and money should be spent on such outcome measures is debatable, given the other activities on which this time and money could be used.

A program needs to have some indication that what it is doing has some positive effects. One of the ways to do this is by carefully implementing activities that have been shown to be effective at reducing risk among youth similar to those it serves.

Proven risk reduction techniques applied in an appropriate way to an appropriate audience should result in positive outcomes. However, results may differ, since there may be differences (in population, staff training, implementation, etc.) between an agency's situation and the one in which an intervention was evaluated.

How Are Outcomes Measured?

One of the outcome measures commonly used by programs for runaway and homeless youth is the percentage of youth who remain in stable placements after they have left the program. While such placement will probably reduce a youth's risk of HIV infection, programs need to remember the following:

- There is no cure for AIDS. Programs need to help youth reduce their risk prior to placement or family reunification.
- All adolescents are at risk for HIV infection. Success at placing a youth in a stable living situation may lower that risk, but does not eliminate it. The knowledge, skills, and attitudes learned by clients need to stay with them and protect them, even in "low-risk" environments.

Many HIV education programs will provide tests or methods of evaluating what clients have learned about HIV. A program may not have the luxury of applying these evaluation methods to all its clients. But it may want to periodically use them. Any HIV prevention program can suffer a diminution in effectiveness because of:

- a change in the risk profile of its clients (e.g., a rise in the popularity of a new drug such as crack cocaine)
- a substantial turnover in staff
- a change in public concern with AIDS
- a change in the clients' ability to understand or relate to HIV education (e.g., an increase in the number of clients who do not speak English as a native language, or an increase in the number of clients whose cultural background and values require a specialized prevention approach)

References to organizations and materials that can help in designing an evaluation component are found in the Resources section.

HIV antibody testing in programs for runaway and homeless youth remains a controversial subject. There are benefits and drawbacks to both testing and not testing. Programs must weigh these consequences, both in terms of their general policy on this issue and for each individual client.

The Role of HIV Antibody Testing

Until recently, most practitioners agreed that HIV antibody testing served little purpose, given the limits of what could be done medically to combat either HIV infection or AIDS. However, in recent years, medical science has started testing (and using) drugs that not only fight the opportunistic infections that attack people whose immune systems have been compromised by HIV, but that also assist the body in resisting such infections in the first place. While far from a cure, these new therapies offer the hope that persons infected with HIV may prolong the period between infection and the onset of symptoms other than the production of antibodies to the virus. It is also hoped that these therapies will assist people in fighting those opportunistic infections, cancers, and the neurological effects that characterize AIDS.

However, many runaway and homeless adolescents do not have ready access to treatment. Programs for runaway and homeless youth, as well as medical clinics that serve this population, are having to grapple with the cost of providing medical services to HIV-infected youth, as well as those with AIDS. Helping a youth overcome the logistical and bureaucratic obstacles to receive those public medical services that are available to them can be a time-consuming and frustrating process, even if these services are ultimately provided at no cost to the program.

While all clients need to avoid those behaviors that put them, and others, at risk of HIV infection, this is even more essential for those infected with HIV. Unprotected sex and sharing needles not only endangers the lives of others, but also can further compromise the medical status of those infected with HIV by exposing them to infections and putting other strains upon an already weakened immune system.

There is a three to six month period before a person infected with HIV develops the antibodies that will result in a positive test. Thus, to be absolutely certain that one is not infected, one must be tested, abstain from all activities that could result in HIV for six months, and then be retested.

Drawbacks to HIV Antibody Testing

Testing can have negative consequences. A negative test result can reinforce adolescents' perception of invulnerability, causing them to engage in activities that put them at risk of HIV infection and other dangers. On the other hand, a positive test result can lead to depression and decrease youths' motivation. The shock can undue much of the progress that caseworkers and their clients have made. One of the important issues in pre- and post-test counseling is to avoid a situation in which a youth gives up as a result of a positive test or is given a license to practice high-risk behaviors because of a negative test result.

Some experts have raised concerns that a positive diagnosis could lead to suicide.

> First, adolescent thinking is characterized by cognitive impulsivity and a sense of invulnerability. Death is often not seen as permanent, even to adolescents. Suicidal adolescents typically view death as a reversible event and perceive suicide as a means of getting even with others. . . . Second, youths living under stressful conditions such as homelessness may be particularly vulnerable to depression and suicide attempts when burdened with further stress. . . . Third, an increased rate of suicide among AIDS patients has been noted.[1]

Any program that provides HIV antibody testing to its clients either directly or by a referral, must take this possibility into account.

Pre- and Post-Test Counseling

A critical feature of any agency that provides HIV antibody testing is the provision of pre- and post-test counseling. Pre-test counseling should include basic information about HIV and AIDS, as well as the limits of HIV antibody testing. Not every youth is a candidate for HIV antibody testing. Pre-test counseling will help determine:

- whether the youth has been engaged in activities that put him or her at risk of HIV infection
- if the youth is emotionally stable enough to accept a positive result; youth who are likely to attempt suicide are often better off not knowing their HIV status (or delaying testing until they can be stabilized emotionally or put into a secure environment in which they can be more closely monitored)

Pre-test counseling also prepares youth for the test results by placing them in a context and outlining the services available if they are seropositive, as well as the services available to seronegative youth to help them avoid becoming infected.

Some adolescent HIV specialists now advocate multi-session pre-test counseling to better assess a youth's emotional stability and ability to follow through with recommended treatment plans.

Post-test counseling is also essential and should always accompany test results. Both positive and negative results can result in adverse reactions on the part of the youth, reactions ranging from suicide in the case of positive results to a feeling of invulnerability and continued high-risk behavior in the case of negative results. Both positive and negative test results can be used to connect the youth more firmly with a runaway program and to make changes to improve his or her life and well-being.

Confidentiality Issues

Few programs that advocate testing advocate anonymous testing for youth (and especially for runaway, homeless, and other vulnerable youth), since such programs cannot ensure that the youth will receive adequate pre- and post-test counseling. Thus, any program that offers or facilitates testing is going to face confidentiality issues—the primary issue being that of who will be told of a youth's HIV status. Obviously the counselor who conducts the pre- and post-test counseling will know this. Whether the information goes beyond this individual without the youth's consent is a complicated question. The fear that their HIV status may become public knowledge could keep youth from being tested (and thus from taking advantage of the early therapies now available that may delay the onset of AIDS). The knowledge that someone in a program is HIV positive can lead to harassment by other clients. It also may cause other youth to be reluctant to use the program (or stay in a shelter) because of unwarranted fear of infection. Without proper education on HIV such fears could also extend to staff and volunteers.

At the same time, an argument could be made that others working with the youth need to know about his or her HIV status. This is especially true of medical or dental personnel. It could also be argued that counselors need to know if a youth is infected with HIV in order to help the youth resolve the trauma that normally accompanies such a diagnosis. Some programs also claim that staff need to know if a youth is infected with HIV so they can be alert for signs of depression or possible attempts at suicide. The issue of whether staff of collaborating agencies (especially other shelters and host homes) need to know a client's HIV status is also complex.

However, medical and dental personnel in many hospitals and clinics have begun taking universal precautions against HIV infection. These precautions (including the wearing of rubber gloves, proper disposal of blood and used instruments, and precautions against needle-stick injuries) are simple and do not depend on knowledge of the patients' HIV status. Such precautions can, in a way, be a model for how runaway programs can simultaneously protect their staff and clients from infection, maintain the confidentiality of HIV positive youth, and provide those youth with the services they require.

It is important to remember that most programs cannot really know which of its clients are (or will become) infected. Thus, at some level, all clients should be treated as if they are infected. This is not difficult. Many of the behaviors that carry risk of infection (such as sex or injectable drug use) are prohibited at shelters and would be even if HIV did not exist. The only additional behavior changes that one might consider are house rules against the sharing of razors and toothbrushes and precautions that should be taken if anyone is bleeding. Such procedures will also reduce the risk of infection with Hepatitis B, which is much more widespread than HIV.

A proportion of the clients of programs for runaway and homeless youth are going to be depressed and perhaps even suicidal given their life experiences. Protocols and policies for such youth should exist in agencies. Any youth whom counselors believe may present a risk of suicide needs to be monitored. Programs need not single out HIV-positive youth for these services. Nor do staff need to know the root cause of a client's depression or suicidal potential. All they need to know is that the youth is depressed or suicidal and should be monitored for self-destructive behavior. One valuable resource that can assist programs in facing the issue of self-destructive behavior is *Evaluation of Imminent Danger for Suicide* by Jon Bradley and Mary Rotheram-Borus.

Thus, confidentiality issues around HIV status may not be as difficult to resolve as they may first appear. The critical factor in such a policy is that youth (especially those considering HIV antibody testing) be aware of what that policy is. It should also be remembered that the more knowledge clients and staff have about HIV, the less concerned they will be about the HIV status of others because they will understand that they cannot be infected by the kinds of casual contact that may occur in programs.

NOTES

1 Bradley and Rotheram-Borus. *Evaluation of imminent danger for suicide.*

CHAPTER 4

While some shelters for runaway and homeless youth maintain that long-term residential services are necessary, others feel they can effectively provide services to youth (and to greater numbers of youth) by limiting the residential stay to a much shorter period, often five to seven days. These agencies claim that for certain runaways and their families, a short shelter stay combined with effective therapeutic intervention can prepare the youth and the family to face the future together (or, if reunification is not an option, to decide on alternative living arrangements). While such programs are not appropriate for all runaway and homeless youth, they represent a valuable model of cost-effective service delivery for one of the largest segments of this population—youth who, although they may have serious problems at home, have not yet been integrated into the street subculture.

This chapter will describe two such agencies: The Bridge for Runaway Youth in Minneapolis, Minnesota, and Huckleberry House in Columbus, Ohio. (There are a number of other "Bridges" and "Huckleberry Houses." Other agencies of these names are not affiliated with the two discussed in this chapter. Nor are these two agencies affiliated with one another.)

Both of these agencies

- were established in 1970 to serve the large numbers of out-of-the-home youth gravitating to college towns
- operate short-term shelters, with an average stay of four or five days
- also service youth on a nonresidential basis
- serve significantly more clients each year than do programs of a similar size that encourage youth to remain in their shelter for a longer period
- reduce risks to youth by encouraging them to use their shelter, rather than the street, as a "time-out" from family conflict
- stabilize youth in preparation for family reunification or, if this is not possible, for an alternative placement
- engage in educational activities designed to prevent HIV infection and the abuse of alcohol and other drugs
- provide extensive aftercare and support services for youth and their families

The Bridge for Runaway Youth, Minneapolis, Minnesota

Since its founding in Minneapolis as a "hippie safe house" in 1970, The Bridge for Runaway Youth (hereafter referred to as "The Bridge") has grown into a short-term shelter and crisis intervention center that serves more than 6,000 youth each year. More than 1,000 of these young people spend time in The Bridge's residential shelter. The Bridge provides counseling to more than 700 families.

Philosophy and Goals

The Bridge is a short-term shelter and crisis management facility whose major goal is family reunification. The average stay is five days. The Bridge's program objectives, as stated in its annual report, are to:

- remove youth from the streets and meet their immediate needs for food and shelter
- stabilize youth emotionally
- identify major personal and family problems and encourage the resolution of family conflict
- break the cycle of family physical, sexual, and emotional abuse
- teach skills that will help youth to develop constructive and realistic options
- reunite youth and families
- involve youth and parents in family and group counseling to reduce interpersonal conflict, improve family functions, and strengthen family relations

Unlike some other programs, The Bridge is willing to work with all families on reunification, providing that the staff is satisfied that no further physical or sexual abuse will take place.

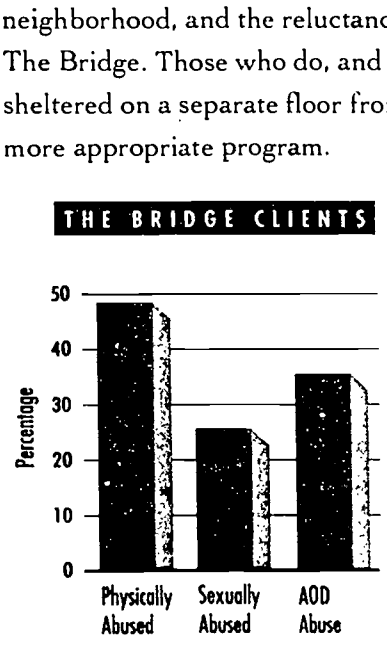
Population and Access

Many of the youth involved with The Bridge first contact the agency through its 24-hour crisis hotline. Others are referred by police officers, outreach workers, or other agencies. A significant number of youth are brought to The Bridge by their parents. Unlike agencies that limit their clientele to youth who have physically run away from or have been forced out of their homes, The Bridge encourages youth who need to leave their families (or families who can no longer tolerate a youth's presence in the home) to come directly to The Bridge, and avoid the dangers faced during even a short time on the streets. This strategy is especially appropriate in the age of HIV where even one unprotected sexual encounter can have fatal consequences.

Not all the youth who come to The Bridge enter the residential program. When a youth or a family calls or comes to The Bridge, an assessment is made to decide if the youth should stay at the shelter or whether he or she can go home and return the next day for a family counseling session. Many can.

The youth in The Bridge's residential program are there voluntarily and with the permission of their families or legal guardians, who are contacted by telephone when their child enters the shelter. Those whose parents refuse to allow them to stay and who are in danger of physical or sexual abuse at home are placed in a foster or group home by the Department of Children's Services. The Bridge does not take court-ordered placements.

The Bridge is willing to work with youth who abuse alcohol or other drugs or who have histories of violent behavior if they agree to abstain from these behaviors while they are in the shelter. Some youth are excluded from the program. Youth thought to be imminently suicidal are taken to a hospital. The staff at The Bridge, like those at many other agencies, believe that it is ineffective to mix youth who have been integrated into the street culture with those who have not. Street youth are not good candidates for family reunification and often cannot tolerate a structured environment and obey rules. Given The Bridge's location in a suburban neighborhood, and the reluctance of street youth to use shelters, few come to The Bridge. Those who do, and who are judged inappropriate for The Bridge, are sheltered on a separate floor from the other youth until they can be placed in a more appropriate program.



While the vast majority of clients at The Bridge are not living on the streets, many still have serious problems. Forty-nine percent have been physically abused, and 26 percent have been sexually abused. Thirty-six percent abuse alcohol or other drugs. Most are sexually active. Many are the children of parents who abuse alcohol or other drugs.

The Bridge is a total therapeutic milieu in which all activities contribute to de-escalating the crisis and preparing the youth for family reunification and participation in the aftercare program.

The Residential Program

The Bridge maintains that sheltering a youth for an extended period allows both the youth and the family to avoid confronting their problems and the difficulties inherent in reconciliation. By limiting shelter care to a five-day stay, The Bridge tries to foster the idea that the family will be living together again shortly, so all members need to work on making that tolerable. However, contact between parents and youth is discouraged while the young person is in the shelter. This provides a time-out period and allows the crisis that precipitated the youth's leaving home to de-escalate.

Youth in the residential program wake up at about 6:30 a.m., take showers, make their beds, have breakfast, and assist the staff in housework. All youth in the program are expected to do chores, including meal preparation and clean-up. Then comes "care plans"—a concrete problem-solving exercise in which the client, with the assistance of the staff, establishes short-term objectives and then develops and implements a plan for meeting those objectives.

After lunch, the residents participate in "themes" and activities. Themes are experiential learning groups focused on topics such as HIV, communication, and substance abuse. Activities are group recreational opportunities that help build group cohesion and establish trust among the residents, staff, and volunteers.

Daily group therapy is held after dinner. Because of the rapid turnover of residents, The Bridge has developed a model of interactional process therapy in which a group goes through all the traditional stages of therapy (beginning, trust-building, interaction, separation, and closure) in one session. After the group therapy comes wind-down time, snacks, and lights-out at 10:30 p.m.

The Bridge describes its residential program as a "total therapeutic milieu" in which all activities, including household chores and recreation, contribute to de-escalating the crisis and preparing the youth for family reunification and participation in the aftercare program. Parents are encouraged to speak with staff about their child's progress and are expected to attend a three-hour parent orientation, which includes an explanation of how The Bridge operates, information on adolescent and family development, and efforts to help parents understand that they are

facing a family problem, not just a problem youth. Referrals for appropriate services, such as treatment for alcohol or drug abuse for parents or youth, are also provided.

HIV Prevention

The latest statistics show the rate of HIV infection in the Minneapolis-St. Paul area to be 7.4 cases per 100,000.[1] Although this rate is well below that of other urban areas, The Bridge has not allowed itself to be deceived as to the very real threat that HIV poses for its clients. Most clients are sexually active. Some have already had children. The majority of those who are sexually active are not using any form of protection and many engage in sex while under the influence of alcohol or other drugs. Some have been involved in prostitution or survival sex.

The Bridge's staff and volunteers are kept up to date on the latest developments concerning HIV, abuse of alcohol or other drugs, risk behaviors, and intervention strategies through an ongoing inservice program as well as training offered through the Metropolitan Training Co-operative. Staff try to bring this knowledge to their clients in many forms: through private interactions, during group and individual counseling, and in activities explicitly addressing these issues.

The most explicit of these is The Bridge's "AIDS, Sex, and Drugs" theme, which is held weekly by staff and volunteers. Although the precise activities of themes at The Bridge change over time, the "AIDS, Sex, and Drugs" theme currently takes the form of a question-and-answer session, in which all participants (including the staff and volunteers) write down questions and put them in a box. The questions are then drawn one at a time and discussed. Staff and volunteers pose questions that give them the opportunity to address the basic issues of HIV and the abuse of alcohol and other drugs. Possibly as a result of school health education programs, most of the youth seem to be aware of HIV, although they often do not apply this knowledge to their own sexual behavior. Therefore, staff feel it important to be explicit about the ways in which people can become infected with HIV.

The staff and volunteers at The Bridge are aware that some of their clients are gay, lesbian, or bisexual. They also are aware that these youth are often hesitant to share this information, as it might cause conflicts with other clients, their parents, or their schoolmates. Issues of gay and lesbian sexuality and the risk of HIV infection are included in the "AIDS, Sex, and Drugs" theme, even if no one in the group is explicitly gay or lesbian. Staff seek to let all their clients know that they are open to discussing issues of sexuality and sexual orientation in private. A

special aftercare group for gay and lesbian youth is available. And both staff and volunteers are quick to enforce the rules that homophobic language (along with ethnic and racial slurs) will not be tolerated in the program.

Issues related to HIV infection and the behaviors that can lead to it are also covered in other themes on "Sexuality" and "Substance Abuse." The theme on "Sexuality" includes issues of sexual and physical abuse. Two additional themes on "Substance Abuse" are offered. One is informational and discusses drugs and their effects. The other is on alcoholic family systems, the effects these systems have on youth, and what youth can do to survive in such situations. The content areas of these themes are reinforced in individual interactions with clients when appropriate.

The staff at The Bridge claim that the abuse of alcohol and other drugs is more common among the parents of its clients than among the clients themselves. In addition to offering support services to youth to deal with those situations, The Bridge refers parents with abuse problems to treatment programs. Intervening in such abuse can be critical to successful family reunification as well as to ending physical or sexual abuse, reducing family tensions, and acting out on the part of adolescents, and breaking the intergenerational cycles of risk behavior that exist in far too many families.

Aftercare and Nonresidential Services

At the end of the youth's stay at The Bridge, the client and the client's family have an exit meeting with a family counselor. If appropriate, the counselor will attempt to get the family involved in The Bridge's short-term family therapy program, whose fee is based on a family's ability to pay. Most families are charged only $5 or $10 a session. Counselors contract with the family to stop any physical, sexual, or emotional abuse that is taking place in the home, gain the family's commitment to staying together, and teach the family to communicate and negotiate differences.

Youth can also attend specialized aftercare groups including a six-week support group on re-entering the family, a group for gay and lesbian youth, and a long-term support group for youth whose parents refuse to participate in family therapy—youth who must learn how to cope with a dysfunctional family until they are old enough for independent living. Youth and their families who have not participated in the residential program can also participate in most of the aftercare programs.

Staff at The Bridge pride themselves on the number of clients who go home and stay there. They understand, however, that not all family problems can be solved with a short course of treatment and, when necessary, encourage families to seek additional help.

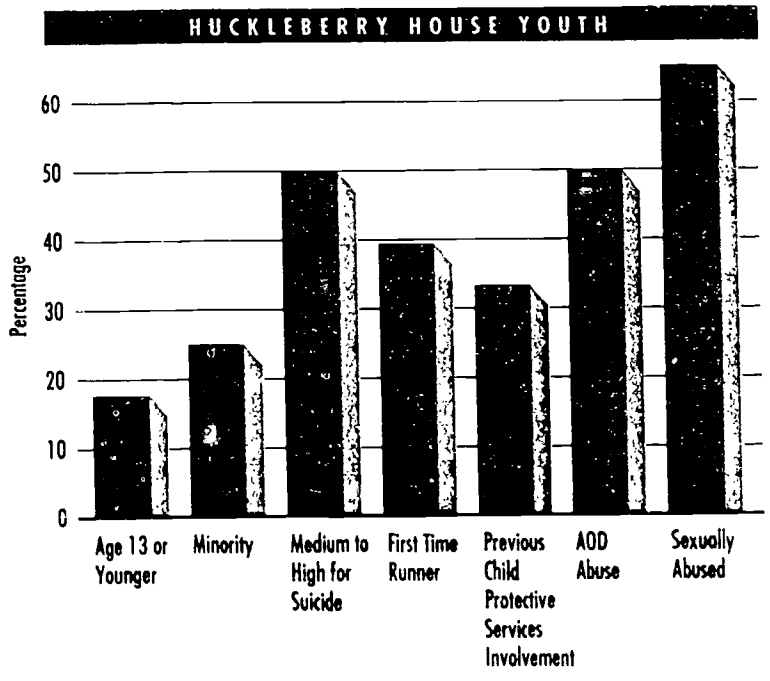
Huckleberry House, Columbus, Ohio

Huckleberry House was established in 1970 as an outreach and counseling center for street youth attracted to the neighborhood surrounding the Ohio State University's Columbus campus. It has since become an agency with a staff of more than 40, assisted by approximately the same number of volunteers, college interns, and high school students.

Clientele

Huckleberry House will not exclude any youth from its program. It accepts both first-time and repeat runaways, as well as youth who are under the influence of alcohol or other drugs. A typical "Huck House" client lives within 15 miles of the agency and has been gone from home less than 24 hours. About a quarter of the clients have not run away from home, but are seeking crisis services. While some agencies will not serve youth still living at home, Huckleberry House maintains that by serving "potential runaways," it can help spare youth the danger and trauma of even one night away from home.

Eighteen percent of Huckleberry House clients are age 13 or younger. About a quarter are from minority families, primarily African American. One-third have previously been involved with child protective services. Half score high to medium for suicide on the assessment tool used at intake. Half abuse alcohol or other drugs. Staff estimate that approximately two-thirds have been sexually abused. Almost 40 percent are first-time runners.



Access and Intake

An important aspect of the Huckleberry House philosophy is access. Huckleberry House provides 24-hour access for both crisis calls and walk-ins as well as referrals to other agencies and services for youth and their families. Services will be extended to any youth, including those typically excluded from other programs (e.g., those who are violent or under the influence of alcohol or other drugs).

Youth come to Huckleberry House through a variety of channels. About 60 percent come on their own or are referred by relatives or friends. About 30 percent are referred by welfare agencies. Huckleberry House also sponsors a Safe Place program involving the fire department and several local fast food franchises. Each participant in the Safe Place program displays a large sign indicating that it will call Huckleberry House to arrange transportation to the facility for any youth who requests it.

The first order of business when youth come to Huckleberry House is to make them feel welcome and comfortable. Youth are asked why they have come to Huckleberry House and are given a tour of the facilities. This welcoming session includes the "house rap" in which key aspects of the program are explained.

- Information given by the youth is confidential; it will be shared only with staff and will not be passed along to parents. Parents and police will not be called without the youth's consent, but staff must tell both parents and police that the child is there if they call and ask. The youth will be informed if this happens.
- Huckleberry House is voluntary. Youth can come and go on their own, but they are encouraged to inform the staff of their plans.
- Staying at Huckleberry House involves an active process of working on problems. Youth must work with a counselor (and, if appropriate, their family) while in residence.
- Counseling is also available to nonresidents.
- Huckleberry House is an active community. Staying there means abiding by certain rules, which include:
  - —helping with chores
  - —attending group meetings
  - —continuing with school and work if possible
  - —complying with the prohibition of alcohol or other drugs, sex, or weapons on premises
  - —keeping the curfew

Youth are not expected to adhere to the regular house schedule during the intake and orientation period. If they are attending school, staff will request that they be excused. This gives the youth time to become acclimated and the crisis counselor time to create a strong and positive connection. After the welcome, youth are given an intake interview, which includes a full assessment and case history, including a screening for physical and sexual abuse, abuse of alcohol or other drugs, and self-destructive behavior. Youth at risk for suicide are closely supervised during their stay and referred for hospitalization if necessary. The intake worker also helps the youth prepare for, and complete, a telephone call to his or her family. In this call, the youth and the family discuss options. Some clients go home or to other living arrangements after this call and do not use other Huckleberry House services.

Crisis and Stabilization Program

About three-quarters of the youth seen by Huckleberry House spend at least one night there. The average length of stay is four days. A youth who opts to stay is assigned a crisis counselor, who meets with the youth and the youth's family, both individually and jointly, several times during the three to five days the typical client remains in the shelter. The counselor seeks to help the family resolve issues that sparked the runaway episode, open lines of communication within the family, make decisions about future options, and provide linkages to other services if necessary. During this period, the youth also continues at work or school, and if possible, he or she meets with other staff and volunteers (including peer counselors) as necessary and participates in groups that focus on problem solving, social skills, and house issues. Other groups focus on the abuse of alcohol or other drugs and HIV prevention. Once a week, an HIV education specialist from the local community health center (affectionately known as the "banana lady") holds a session for clients to provide them with information about HIV, including the use of condoms and other practical steps they can take to reduce the risk of infection.

Of primary importance is the intake interview, which includes a full assessment and case history, including a screening for physical and sexual abuse, abuse of alcohol or other drugs, and self-destructive behavior.

Prevention of the Abuse of Alcohol or Other Drugs

The fact that Huckleberry House allows youth under the influence of alcohol or other drugs onto its premises and into its shelter distinguishes it from the majority of programs for runaway and homeless youth. Huckleberry House maintains that a commitment to serving youth in crisis means that it must take youth as they come, even if that means they are intoxicated. On a practical level this means that "if they show up and can't talk or think straight, you stay with them until they can."

Huckleberry House maintains that a commitment to serving youth in crisis means that it must take youth as they come, even if that means they are intoxicated... this means that "if they show up and can't talk or think straight, you stay with them until they can."

Huckleberry House rules do say that once a youth chooses to stay in the shelter, he or she cannot use or possess drugs. However, youth who break this rule are not excluded from the program. Rather, a staff member will sit down with the individual, discuss the violation of the rule, and contract with the youth on ways to avoid rule-breaking in the future. Huckleberry House staff also believe that, in the case of the abuse of alcohol or other drugs, these contracts must be manageable. Youth cannot necessarily be expected to fulfill a contract to just "not use drugs or alcohol." Rather, staff might, for example, encourage a youth to think about the way he or she felt before drinking or using other drugs, and contract to speak with a counselor the next time he or she feels that way.

This approach toward the abuse of alcohol or other drugs is indicative of the Huckleberry House philosophy of empowerment. It seeks to help the youth work on an agenda, to make choices and be responsible for the consequences. The abuse of alcohol or other drugs is seen as a support (although a dysfunctional one) youth use to deal with their lives. Such abuse can be replaced with other supports, such as self-esteem, negotiation skills, and positive relationships. Thus, merely contracting with youth to not use alcohol or other drugs is ineffective unless some support is offered in its place.

Aftercare

An exit interview prepares the client for returning to the family or entering another living option. The youth is encouraged to return to Huckleberry House if he or she feels unable to remain in the placement, be it the family or some alternative. If aftercare is recommended, an aftercare counselor participates in the exit interview to encourage families to participate. The aftercare program, known as Parents and Teenagers (PAT), provides case management as well as individual, family, marital, and group counseling at no cost to clients. About half the youth who stay in the shelter participate in the aftercare program. Those who do not are usually already involved in counseling elsewhere. PAT also takes referrals from the community for children at risk of running away.

During the first aftercare session, the youth and family identify their goals and sign a contract concerning the aftercare process. A session to evaluate progress is usually held four to six weeks later. At this session, the youth and family decide if they will continue in aftercare and, if so, whether their goals need to be revised. The length of the aftercare process is tailored to each family. PAT also runs other types of support groups in which family members can participate, including teen groups and groups for those who abuse alcohol or other drugs.

Follow-up

Termination can occur because a youth and his or her family have reached their goals or because a youth drops out of the program. A call is made 60 to 90 days after termination to see how the family is doing and to re-involve the family (or refer to other services) if appropriate. Eighty-three percent of clients placed by Huckleberry House were found to still be in the placement at the 90-day follow-up check.

Home-based Services

The home-based services program began when staff noted that those youth who scored highest on the Severity of Problem (SOP) intake instrument were receiving the lowest level of services. The home-based services program was designed to take services to youth and their families who were desperately in need of them, but were unable or unwilling to participate in Huckleberry House's on-site programs. The typical family receiving home-based services has a long-term multigenerational

history of dysfunction, abuse, and isolation. These are often poor, single-parent families with a pronounced lack of trust in social service agencies and nonexistent or dysfunctional support networks.

Services provided by the home-based services program include counseling, tutoring in budgeting and parenting skills, and help in housecleaning and child care. The intensive home-based service period typically lasts from three to four months. After this period the counselor assigned to the family terminates his or her role as the primary service provider and acts as a case manager, helping the family obtain services from other agencies and organizations.

Evaluation

The Franklin County Board of Alcohol, Drug Abuse, and Mental Health, which funds Huckleberry House's aftercare program, requires monthly data reports from all of its grantees. By the tenth working day of each month, reports are produced on the previous month's statistics, as well as year-to-date totals and comparisons with the previous year. This reporting requirement led Huckleberry House to establish an unusually strong evaluation program. The information generated by this system is used by staff to evaluate and improve their performance by focusing on outcomes. The outcome statistics in the evaluation report are based upon a comparison of functioning and severity levels at intake and termination. Functioning and severity levels are measured by two self-administered instruments, the Severity of Problem-scale and the Family Satisfaction Scale. Other data used in evaluating the programs performance including the number of youth who drop out of the program and the number of youth who return, and remain, at home.

Youth Outreach Project

Like many other agencies that serve runaway and homeless youth, Huckleberry House also offers programs targeting other high-risk youth. The Youth Outreach Project is a youth gang and violence intervention project established in 1986 by a coalition which included the United Way, the Columbus Parks Department, and the Columbus School System. Dissatisfied with the initial management structure of this project, the coalition asked Huckleberry House to take over the coordination of the project in 1989.

The Youth Outreach Project involves eight full-time staff and a coordinator. They work with high-risk youth in three settlement houses and conduct "hot spot" interventions at places where youth gather, including football games, concerts, dances, and street corners.

NOTES

1 Centers for Disease Control. *HIV/AIDS surveillance: Year-end edition.*

CHAPTER 5

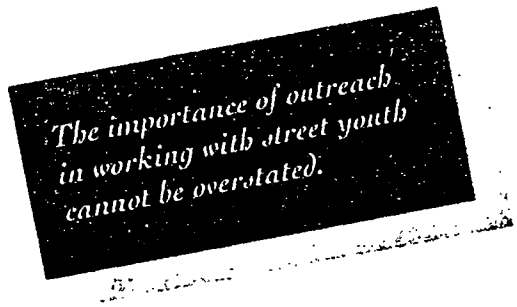
While substantial numbers of runaway youth may be able to reunite with their families through the use of short-term crisis intervention programs, there is a group of youth for whom this is not possible. These are "street youth." "Street youth" is not a very satisfactory or precise term. It often conjures up an image of a tough-looking panhandler or a teenage prostitute flagging down passing automobiles. While these clichés contain some truth, the facts are much more complex. The term "street youth," like "runaway," is difficult to adequately define. Despite their ambiguities, both terms are serviceable enough to be widely used by researchers and practitioners.

Street youths are runaways (and often throwaways) who have spent extended periods of time living out of the home. Some may periodically return home, but most live on their own, or with other homeless adolescents, sleeping in cheap hotels, bus stations, or abandoned buildings, and supporting themselves through robbery, prostitution, drug dealing, or panhandling. Most think of themselves as homeless, as not having a home or a family to which they can return.

Of all runaway youth, they are most at risk. Many of them have been physically or sexually abused in the home. They have often severed relations with their families, their schools, and their peers. They spend much of their time "on the streets," totally unsupervised by concerned adults and without positive peer models. They have no stable support system. They do not get enough sleep, food, or medical care. They do not go to school. They are often victimized by adults and peers. While many of them have developed survival skills and may appear "street smart" and even dangerous, these skills do little for their long-term benefit. They are the runaways most at risk of rape, prostitution and other forms of sexual exploitation, sexually transmitted diseases, the abuse of alcohol and other drugs, and HIV infection.

While only a minority of street youth, both male and female, prostitute themselves, many more engage in survival sex, both with their peers and with older members of the street culture. A relationship with a "boyfriend" or "girlfriend" may exist only as long as that person can provide a place to stay, or food, or drugs.

Street youth are not restricted to New York City's Times Square or along Santa Monica Boulevard in Los Angeles. Virtually every major urban area in America has a neighborhood in which these youth can be found. Practitioners with a great deal of experience with street youth and youth involved in prostitution claim that they can be found in most small cities if one knows where to look and how to differentiate them from teenagers who are just "hanging out."



Meeting the service needs of such youth is an extraordinary challenge. They are often alienated and lack trust in adults, especially those representing social service or law enforcement agencies. Many are running from court-ordered placements or foster homes.

Street youth tend to shy away from programs with too many rules; many avoid programs altogether. The importance of outreach in working with street youth cannot be overstated. It is only through the trust-building that takes place during outreach that many of these youth can be convinced to take the first step toward more consistent involvement in programs. Outreach is also useful for identifying youth who have not been integrated into the street culture and may still be responsive to shelter care and family reunification.

Street outreach workers also face the difficult challenge of trying to protect these youth from HIV infection while they are living in an uncontrolled and extremely high-risk environment. Not only do these youth lack adult supervision and positive peer roles, but they also face a host of emotional, cultural, and financial forces that impel them toward unsafe sexual activities.

An invitational meeting of street outreach workers convened by the Center for Population Options in May 1989 recommended five guidelines for developing HIV programs for runaway and homeless youth.

- An HIV education program must be part of a broader effort to address youths' hierarchy of needs.
- The individual characteristics of street and homeless youth must be acknowledged and addressed through programmatic adaptations.
- Finding a credible messenger is crucial. Street and homeless youth, many of whom have been victimized, may be unwilling to trust any outsider. . . . Peer programs may be an effective solution.
- It is important to develop simple, straightforward HIV prevention messages that can be delivered through many different programs in limited amounts of time.
- Service providers, as advocates for street and homeless youth, must recognize and communicate to the broader community the danger that HIV infection poses to these youth.[1]

Crisis intervention presents other problems. The crisis that provoked the youth into leaving the home is effectively ended by the youth's decision not to return (or, the realization that a return is not possible). However exploitative the relations on the street may be, the street culture does provide a certain degree of support and community. Street youth form "families" which, although transitory, provide some comfort and emotional and financial support. They develop relationships with older street people who are often both exploiters and protectors. They find "jobs," even if these jobs are drug-dealing, robbery, and prostitution. And they find a level of independence, which is difficult for them to relinquish upon entering a shelter.

Some outreach workers maintain that street youth must "bottom out" before seeking help. Given the dangers of life on the street, hitting rock bottom can often involve a medical or psychological crisis profound enough to threaten a youth's life and to push the limits of a service provider's capabilities.

Stabilization is also difficult. It often requires more than just emotional stabilization, including adjustment to living in a structured environment and reindoctrination into some requirements of the mainstream culture (e.g., taking showers or sleeping at night rather than during the day). But without stabilization, these youth cannot be expected to succeed in any more formal structure, be it school, their homes, foster or group homes, or transitional living programs. Many street youth will leave (or be expelled from) a program a number of times before they are able to successfully make the transition to a structured environment. Thus, programs for these youth must try to help them develop those skills that will reduce their risks (for HIV infection and other dangers) during periods of transition.

The type of treatment for the abuse of alcohol and other drugs that street youth need often requires specialized medical services. Few, if any, runaway programs can afford to provide such services. Most refer these clients to specialized placements. Unfortunately, there are simply not enough beds available in alcohol/drug treatment programs (and especially in treatment programs specializing in adolescents).

Since many street youth, even after successful stabilization, cannot, or will not, return home, and are too old or too independent for alternative placements, many enter transitional (or independent) living programs. These programs seek to prepare youth for a life as independent, functioning young adults by teaching various

life skills including budgeting, job-hunting, and apartment-hunting, as well as by providing academic education and the range of remedial social skills that many runaways need.

Many programs for runaway and homeless youth now face the issue of long-term medical and hospice care for youth infected with HIV. Such care is expensive, requiring medical equipment and personnel. Unfortunately, as HIV spreads, and youth become infected at an earlier age, more programs will find themselves facing this issue more often. The cost of medical care, even for small numbers of HIV-infected youth, will tax programs' financial resources and traditional methods of providing services. Successful HIV-prevention activities for runaway and other at-risk youth may be essential not only to their survival, but ultimately to the survival of the agencies that serve them.

This chapter presents case studies of three different models of street youth services programs representing widely separated parts of the country. They include:

- the Los Angeles Youth Network, a residential shelter located in Hollywood
- Urban Peak, a drop-in center in Denver, Colorado
- Streetworks, an outreach program serving the youth of the Times Square area of New York City

Los Angeles Youth Network, Los Angeles, California

The Los Angeles Youth Network (LAYN) has two facilities, both located within four or five blocks of Hollywood and Vine in the Hollywood-Wilshire section of Los Angeles, California. This area is home to a large and visible population of runaway and homeless youth, many of whom can be seen along the "main drags" of Santa Monica and Hollywood Boulevards, hanging out; buying, selling, and using drugs; and offering themselves for prostitution to passing motorists. The Hollywood Youth Emergency Shelter provides a secure sleeping place for youth 12 to 17 years of age. The Cahuenga Outreach Center provides drop-in services, referrals, counseling, and a simple respite from the street for youth up to age 23 (although most older youth are referred to other agencies). LAYN is a major subcontractor of the High Risk Youth Program of Childrens Hospital Los Angeles (described in Chapter 6).

Clientele

Although some LAYN clients are referred by other agencies, most walk in on their own accord, having heard of the program from other youth or outreach workers. LAYN serves over 1,000 youth each year. Ethnically diverse and ranging in age from 12 through 23, these youth come from every state as well as a number of foreign countries. LAYN estimates that approximately a quarter of its clients have been involved in prostitution and that over half have been sexually abused, either at home or in foster placements. Most of its clients have been on the street for at least five months. Most are polydrug users, who will use whatever drug is available. Although less than 5 percent use injectable drugs, over 30 percent have had sexual contacts with injectable drug users.

LAYN feels that certain youth can be served more appropriately at other programs. First-time runaways are referred to programs such as Stepping Stone in Santa Monica, which provide services and an atmosphere more appropriate to these youth. Addicted youth are referred to programs that have the space and medical staff needed for drug detoxification.

LAYN has found that an increasing number of undocumented immigrants have been appearing at the drop-in center. Many of them are Central American refugees fleeing poverty and political violence. Many suffer from post-traumatic stress syndrome. These youth are usually referred to the Immigrant Refugee Children's Project of the National Center for Immigrant Rights, where they can receive culturally specific legal, psychological, and other services.

Drop-in Services

The Cahuenga Outreach Center provides day services to youth in LAYN's residential program and to other youth on a drop-in basis. One large room at the center is used as a "day shelter." Youth are allowed to stay there during the day, watch television, and nap (a valuable service given that many of them are up all night). During certain periods, the center is used for group activities (focusing on topics such as the abuse of alcohol and other drugs, HIV education, and sexuality). Youth who are not participating in these groups must leave the building. Youth who have violated center rules (such as those concerning the use of alcohol or other drugs or violence) will sometimes be barred from the facility for a month or two before being given another chance.

Shelter Care

Most shelter intake is done through the outreach center (although emergency intake is also done at the shelter evenings and nights, when the outreach center is closed). A youth requesting shelter will be given an appointment with an intake caseworker. The receptionist will see to it that any immediate needs (e.g., for food) will be taken care of during the youth's wait for the caseworker, which can be from 15 minutes to more than an hour. During intake, the caseworker assesses the youth's needs and explains LAYN's policies and services. In California, a youth cannot be sheltered by a nonrelated adult for more than 72 hours without permission from a parent or guardian. Thus, during the first 72 hours in the shelter, staff will attempt to contact the youth's parents or legal guardian; in the case of wards of the court, staff will contact a social worker to obtain such permission. If a parent or legal guardian cannot be located, the Department of Children's Services can issue an authorization for shelter care.

If a client does not join LAYN's stabilization program during his or her first three days in the shelter, he or she must leave. Normally, shelter care is extended to only those youth who cooperate with the staff in contacting their parents and who are seeking reunification or stabilization services. However, youth are occasionally allowed to use the shelter for an overnight as a respite from the streets; such "emergency overnights" are limited. Priority is given to those youth who want to make a change in their life situation, as staff have found that emergency overnights can lead to program involvement.

The Stabilization Program

The Hollywood Youth Emergency Shelter closes during the day. After breakfast, shelter residents are bused to the Cahuenga Outreach Center. The stabilization program's goal is to help youth attain a level of structure in which they can return to their family or enter another program (such as a long-term placement or a transitional living program). A youth in the stabilization program will develop a case plan with the caseworker. Although the LAYN always places a priority on the possibility of family reunification, only a minority of its clients are able to achieve this. Most stabilization case plans for those under 16 involve foster placement. For those over 16, stabilization normally sets independent living as its outcome. Although some youth stay at the shelter for the maximum allowable period of 60 days, the average period of stay for those youth who have joined the stabilization program is 20 days.

Seventy percent of the youth who go through the stabilization program are still in their placements 120 days after leaving the program.

During the day, youth in the stabilization program are involved in a number of activities. This can include school or part-time employment, individual and group counseling activities, sessions aimed at reducing the abuse of alcohol and other drugs, HIV education groups, creative writing or art classes, and recreational trips to the YMCA or matinees at downtown theaters. None of the activities are mandatory, although counselors help youth clarify which activities would be beneficial to their case plans. Nonsheltered clients are also involved in these activities (some even have case plans) although one must be a residential client to participate in the stabilization program.

Unlike other programs, LAYN does not do therapy as such. It does employ a psychologist part-time who does assessments and offers to see youth on a crisis basis (such as after they have had a telephone conversation with their parents). This psychologist does not attempt traditional therapy in either facility but attempts to assist youth at crisis points and help them clarify their goals in the program. More traditional session-based counseling for runaway and homeless youth is offered at the L.A. Free Clinic.

Follow-up calls are made to youth 30, 60, 90, and 120 days after leaving the program. Seventy percent of the youth who go through the stabilization program are still in their placements 120 days after leaving the program.

HIV Prevention

A "Let's Talk about AIDS" group is held at least once a week in both the outreach center and the shelter. Most clients in the stabilization program are involved in this group at least once a week. Many of the youth who are using the shelter for an emergency overnight, who are in their first 72 hours, or who are being day sheltered in the drop-in center also participate to avoid being excluded from the building while the group is taking place. HIV education is also presented by a teen improvisation theater group, which periodically performs at both LAYN facilities.

Caseworkers at LAYN try to integrate HIV education into their everyday interactions with clients. If a client mentions using alcohol or other drugs, the caseworker will try to relate these behaviors to the risk of HIV infection. LAYN distributes condoms and bottles of bleach (although not needles) to its clients, both in the outreach center and during street outreach activities.

Outreach

Outreach efforts (done in conjunction with other programs of the High Risk Youth Program described in Chapter 6) focus on HIV education and motivating youth to become involved with appropriate programs. Much outreach done from LAYN focuses on Santa Monica and Hollywood Boulevards, where runaways involved in prostitution solicit customers, and in nearby parks where many homeless people sleep. Outreach workers work in small teams and are readily identifiable by the bags of bleach and condoms that they carry. They approach groups and individuals, talk with them about AIDS and other issues, distribute bleach and condoms, and publicize the free medical services available through the L.A. Free Clinic (described in Chapter 6). When appropriate, they will refer youth to various programs in the area, including LAYN. Street outreach workers will generally talk to anyone who is young and homeless or looks as if they might be spending a lot of time on the streets.

The primary goal of this street outreach is to try to reduce the risk of HIV infection by encouraging the youth to use condoms. Outreach activities are coordinated and organized. Youth know that outreach workers will usually be in particular areas at particular times and can provide information, condoms, bleach, referrals, and bus tokens or car fare to get them to services.

URBAN PEAK, DENVER, COLORADO

Urban Peak was founded in 1988 by a Denver neighborhood organization, the Capitol Hill United Neighborhood Improvement Fund (CHUN-IF), in response to a large and visible population of street youth and youth involved in prostitution in the neighborhood. Although initially funded through a grant from the Colorado Juvenile Justice Council, Urban Peak now receives funding from a broad spectrum of private and public organizations and is the recipient of in-kind contributions and pro bono services from a wide range of community, religious, and professional organizations.

Clientele

Many of Urban Peak's clients are engaged in prostitution or survival sex, and/or abuse alcohol and other drugs. They are often estranged from their families. Many have serious emotional or medical problems. They are often malnourished and live on the streets, in abandoned buildings, or in shared, inexpensive apartments. They generally do not make use of shelters (of which there are several in Denver) or are

excluded from these programs because of their abuse of alcohol or other drugs or perceived capacity for violence. Forty percent of Urban Peak's clientele are youth of color (African American, Latino, and Asian) and about 25 to 30 percent identify themselves as gay or lesbian.

Services

Urban Peak seeks to assist young people in finding alternatives to living on the street. Many of their clients come in of their own accord or are brought in by other youth, attracted by food, recreation, and a warm, safe place to spend the day without the demands of shelter residence.

Urban Peak also runs an aggressive street outreach program in which teams of workers (including staff, volunteers, and peer outreach workers) approach youth on the streets and provide referrals, bus tokens, condoms, and advice. They try to establish trust and convince youth to come into the drop-in program. This activity is partially funded by Colorado Off Streets Off Drugs (COSOD), a collaborative effort funded by the United States Department of Health and Human Services.

Urban Peak provides individual and group counseling, as well as specialized groups that focus on sexuality, family alcoholism, surviving incest or rape, and self-esteem. A support group, The Peak Experience, is available for those seriously attempting to turn their lives around and succeed at independent living.

One of the prime draws of Urban Peak is its free meal program. Urban Peak serves six meals a week, often using food and volunteer labor donated by local restaurants, church groups, and fraternal organizations. Urban Peak also operates a food distribution program, which distributes free groceries to youth once a week, providing they have signed up for this service in advance and have not failed to pick up their groceries on any previous occasions.

Urban Peak sponsors an on-site medical clinic two days a week, using staff provided by the Stout Street Clinic, a local health center for the homeless.

Urban Peak also operates a transitional living program partially funded by Youth 2000, a public/private partnership targeted to at-risk youth. Program components include the following:

- Outpatient drug treatment, subcontracted through the University of Colorado Health Science Center's Addiction, Research, and Treatment Services (ARTS), requires periodic urine tests to ensure that participants are drug free.

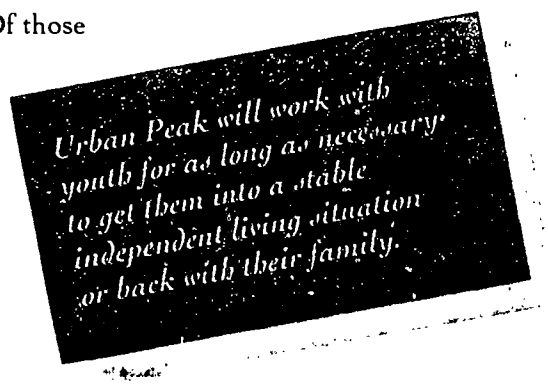
- Educational programs leading to a high school or general equivalency diploma are subcontracted through a local nonprofit agency, New Pride, which also operates a six-week vocational education and job placement program.
- Subsidized apartments are available for those in the independent living program. These apartments are found with the assistance of local realtors. Urban Peak partially subsidizes the apartments for the first three months (providing up to $200 the first month, 75 percent of the first month's subsidy the second month, and 25 percent of the first month's subsidy the third month). Urban Peak also provides clothes, furniture, and groceries to youth participating in this program. Requirements for receiving such a subsidy include participation in the drug treatment and/or educational programs if appropriate.

Urban Peak hires some of its clients for use as peer leaders (who do intakes), outreach workers, receptionists, and custodians. These positions are fairly short-term (approximately nine months) so that the experience can be available to other clients. Urban Peak also organizes recreational activities such as group excursions to football games and concerts.

Urban Peak will work with youth for as long as necessary to get them into a stable independent living situation or back with their family.

Outcomes

Urban Peak staff realize that they cannot show the success rates of programs that serve youth who have not yet been integrated into the street culture. A significant portion of Urban Peak's clientele appear and disappear over the course of their "street careers." About a third of the youth who have used the program in its first two years ended up being classified as "status unknown." They may have gone back to live with their families, made a transition to a more stable lifestyle, left the area, or gone to jail. They may still be on the streets and may reappear at Urban Peak at some point in the future. Of those who can be tracked, 38 percent eventually reunite with their families, 28 percent go on to independent living, 4 percent end up in jail, and 15 percent remain on the street.



Staff and Volunteers

One of Urban Peak's more notable features is its extensive use of volunteers. Some of these volunteers are paid by ACTION (the federal agency now overseeing the VISTA program). Others are interns from local colleges. But the majority of volunteers are simply people who want to help. Volunteers facilitate groups, prepare meals, do street outreach, take the youth to do laundry, publish *The Peak Experience* (Urban Peak's newsletter), lead recreational activities, and engage in fundraising. Volunteers from the Colorado Mental Health Association do clinical consultations with staff twice a week. Urban Peak has a staff volunteer coordinator who recruits, screens, trains, and coordinates volunteers.

Urban Peak also takes steps to minimize burnout, a common problem in programs serving street youth, given the low pay, long hours, and frustration at the number of clients who seem to slip back into the street life and their old risk behaviors time and time again. Weekly process groups, as well as an annual retreat, help staff come to terms with the frustrations they face in their jobs. The outreach and counseling staffs also have weekly meetings for information-sharing and case management, which are especially critical in programs with clients still living on the streets. Urban Peak also holds a weekly community meeting in which staff, volunteers, clients, and parents get together, discuss issues relating to Urban Peak's mission and activities, and offer support to one another. These sessions are also a forum for expression of public appreciation: various members of the Urban Peak community are honored for their contributions to the program, and clients are recognized for their personal progress. At these meetings, people are awarded paper stars for achievements ranging from helping to prepare a meal to terminating cocaine use. Such tokens may seem insignificant, but can go a long way to providing positive reinforcement to an adolescent feeling his or her way back from the street life, a parent trying hard to break old habits and learn more positive parenting methods, or an underpaid, and often, unsung counselor.

STREETWORK PROJECT, NEW YORK, NEW YORK

Streetwork Project was established in 1984 by the Victim Services Agency to (1) divert runaway and homeless youth from prostitution, (2) create a bridge between street life and health and social services, and (3) help youngsters living on the streets leave the streets.

Streetwork focuses on perhaps the highest-risk population of any runaway program: the street youth of New York City. These youth are alienated and suspicious of authority, and often refuse to make use of shelters or other available resources. They live on the streets or in abandoned buildings in one of the country's largest, roughest, and most troubled urban areas. Most use alcohol or other drugs. Many use injectable drugs or crack, both of which increase their risks for HIV infection (the first directly, the second because crack users often turn to prostitution or trade of sex for drugs). Many are street prostitutes in a city with one of the highest HIV infection rates in the country.

Youth are introduced to Streetwork's services through staff street outreach efforts and word of mouth. A storefront drop-in center in Times Square provides a safe place to take a shower, participate in groups, and meet with counselors who will help them find housing, food, clothing, medical treatment, drug rehabilitation services, and mental health services. The project also offers HIV education, both through workshops and informal street meetings. Between 25 and 40 youth a day visit the drop-in center. The project has street contacts with about 12,000 youth every year.

The median age of clients is 19. Seventy percent come from within the city; the rest from surrounding communities. Very few are from outside the New York metropolitan area. Forty-two percent of the males identify themselves as gay, and 73 percent of clients report being involved in prostitution. Eighty-seven percent report drug use, mostly crack.

Most staff have youth service or human service backgrounds and have worked in shelters or similar environments. Prospective staff undergo a rigorous interviewing process and receive intensive, one-on-one training from seasoned staff members. Staff retention has been excellent (three to five years), which the project director attributes to the project's philosophy, opportunities for promotion, and the ability to move counselors off the street after about two years.

Building trust with runaway and homeless youth can be a long and difficult process. Streetwork reports that it can take several years of working with a youth on the streets before he or she has developed enough trust to enter a shelter or other placement. New York's transitional living facilities cannot begin to offer placements to the number of youth in need of such services. While pessimistic about their ability to prevent many of these youth from becoming infected with HIV during their lengthy stay on the streets, Streetwork staff remain committed to attempting to reduce risk among this population.

NOTES

1 Wigfall-Williams. *Out of the shadows: Building an agenda and strategies for preventing HIV infection and AIDS among street and homeless youth.*

CHAPTER 6

The Los Angeles High Risk Youth Program

No single program can provide every runaway youth within its catchment area with every necessary service. The problems affecting these youth are diverse, complex, and deep-seated. The range of medical, legal, psychological, and educational services needed is great enough to tax the resources of the largest and most well-endowed agency. The key to providing services to this population is collaboration and networking: finding ways that agencies and specialized services can work together to meet the needs of runaway youth in a manner that is both affordable and efficient. While efforts are being made at such collaborative and networking activities in a number of places, we chose to focus on the constellation of programs that exist in Los Angeles County, California.

The High Risk Youth Program (HRYP) is a coordinated system of care for runaway and homeless youth in Los Angeles County. The components of this system, which represent more than 30 public and private agencies, are held together by subcontracts, collaborative agreements, and cooperative activities coordinated through the Division of Adolescent Medicine of Childrens Hospital Los Angeles (CHLA). Funding comes from a number of state, federal, and private sources.

Runaway and Homeless Youth in Los Angeles

Los Angeles covers over 465 square miles and has a population of about 3 million people. It is one of the few places in the country that attracts substantial numbers of runaway youth from outside the immediate area. One agency has seen youth from every state and at least six foreign countries in the last three years. Some of these young people come to Los Angeles with dreams of success in the entertainment industry. Others are drawn to the climate and the large street culture into which they can disappear. A 1981 study found that 10,000 runaway and homeless youth lived in Los Angeles County, with that population doubling during the warm summer months.[1] There is no reason to think that this number has declined in the last decade.

While serving all types of runaways, the HRYP puts a special emphasis on services to the homeless street youth of the Wilshire-Hollywood section of Los Angeles, an area in which drug abuse and prostitution are common. These youth are at extremely high risk for HIV infection. They often have complicated psychosocial problems that make intervention especially challenging. A study of runaway and homeless youth in this area revealed that:

- 64 percent live in "improvised" situations (abandoned buildings, under highway overpasses, etc.)

- 30 percent have prostituted themselves; 22 percent have traded sex for food or shelter; almost 11 percent have traded food for drugs
- 60 percent were physically abused while at home
- almost 17 percent reported being sexually abused by a family member and 24 percent being sexually abused by "others" (although the researchers felt that the actual percentages are much higher, given the number of youths who refused to answer these questions)
- almost half abused alcohol; almost 39 percent were diagnosed as drug abusers by a clinical definition; more than 77 percent had used drugs during the past 30 days
- 92 percent were sexually active; 81 percent used no birth control; out of those who did, only 53 percent used condoms. Forty-four percent of the girls had been pregnant at least once[2]

The data on youth who participate in the HRYP medical clinic are similar: 38 percent live on the streets, 36 percent with friends, and 7 percent in shelters. Eighty-four percent have used alcohol or other drugs and 34.5 percent have used drugs intravenously. Twenty-two percent report being sexually abused in the home and 26 percent admit having engaged in survival sex. Eighty-five percent are diagnosed as depressed and 9 percent as actively suicidal.[3]

Components of the High Risk Youth Program

The Division of Adolescent Medicine at CHLA is attempting to create a coordinated system of care for runaway and homeless youth in Los Angeles by:

- coordinating the services of the various agencies and programs that serve these youth
- obtaining funds to augment the activities of the participating agencies in ways that expand their capacity while maximizing interagency collaboration and the efficient use of resources
- creating new programs to fill service delivery gaps in ways that complement and strengthen, rather than compete with or threaten, existing agencies and programs

Through a series of grants, subcontracts, and collaborative arrangements, the Division of Adolescent Medicine brought together a large number of public and private agencies to provide the runaway and homeless youth of Los Angeles County with a wide range of essential services.

The High Risk Youth Program Clinic

The core of the HRYP is a free medical clinic held twice a week at the facilities of the Los Angeles Free Clinic. Youth are referred to the clinic by one of the many youth shelters, drop-in programs, or outreach teams operating in Los Angeles County. Many of these programs give youth bus vouchers to enable them to get to the clinic. Although youth generally come because of a specific medical complaint, they receive (at no cost) a general medical screening as well as a psychosocial interview.

Basic information is gathered on each client during intake. The youth is then examined by a physician (a medical student, resident, or doctor from the post-residency fellowship program at CHLA). During this medical examination, the physician also conducts a short psychosocial assessment. This interview, known as HEADSS (Home, Education, Activities/Affect, Drugs, Suicide, Sexual history), was developed by Dr. Harvey Berman of Seattle. It is a method of quickly gathering basic information that can be used to measure a youth's risk status for such problems as the abuse of alcohol and other drugs, HIV infection, depression, suicide, and violence.

The HRYP offers HIV antibody testing to those clients it feels are at risk for HIV and would benefit from knowing whether or not they are HIV positive. All clients of the HRYP have blood samples drawn during their initial examination. Two samples are drawn, one for the standard battery of medical tests given during the examination, and one to be held in case the client and his or her counselor decide that HIV antibody testing is appropriate. The decision to recommend HIV antibody testing is made by the physician and the triage team. This decision is based on a number of factors, including medical condition, risk status, and whether or not the youth is judged to be at high risk of suicide, should he or she test positive.

If the youth requests, or the triage team recommends, HIV antibody testing, the client will first meet with a staff member certified (by the county) as an HIV-testing counselor. The counselor will explain HIV antibody testing to the youth, go over the basic facts about HIV and AIDS, and explain the arguments for, and against, testing. If the counselor and the client decide that testing is appropriate, the test can be done using the previously drawn blood sample. (If an HIV antibody test is not done, the staff disposes of this sample.) Upon completion of the test, the client is informed of the results in another session with the counselor. This is especially important, as either a positive or a negative result can have important

consequences for the client. HIV-positive youth need both medical and support services for the protection of their health and the health of others. HIV-negative youth need to understand that they are still vulnerable to the virus and must be educated in the ways in which they can reduce this risk. Clients can react to either diagnosis by seeking services or by rejecting them. It is only in the context of pre- and post-test counseling that HIV antibody testing is meaningful in protecting both the individual's and the public's health.

After examining the youth, the physician presents the results of both the medical examination and the psychosocial interview to a triage team consisting of a medical preceptor and specialists from the Substance Abuse Treatment and Risk Reduction Programs (described below). The medical preceptor evaluates the client and offers advice on the diagnosis made by the examining physician; the team then makes a recommendation for disposition. Although most of the youth seen are engaged in multiple risk behaviors, the triage team will determine which behavior may be most pressing (or what might be used to motivate further involvement with the HRYP). The team then refers the youth to a representative from one of the specialized programs affiliated with the HRYP.

A youth who is a first-time runaway and a good candidate for family reunification might be referred to a shelter that specializes in short-term crisis intervention or family reunification. A chronic runaway or youth who has been thoroughly integrated into the street culture would be referred to one of a number of shelters and drop-in centers that specialize in working with these youth. Specialized shelters are also available for youth who are recent immigrants.

A youth who is a first-time runaway and a good candidate for family reunification might be referred to a shelter that specializes in short-term crisis intervention or family reunification.

Other youth may be referred to services available through the HRYP itself. These include pregnancy counselors (who offer information on birth control, prenatal care, and entrance into specialized residential programs for pregnant teenagers) and a clinical psychologist who

provides services for both the HRYP clinic and several of its affiliated agencies. This psychologist offers assessments and referrals to other specialized psychological services (including culturally specific psychological services and inpatient centers). He also has a caseload of runaway and homeless youth whom he counsels on an outpatient basis. Some of his clients are involved in other components of the HRYP; others still live on the streets.

The HRYP (as well as the other shelters and programs affiliated with it) also refer youth to two specialized risk reduction programs funded through CHLA: the Substance Abuse Treatment and Risk Reduction Programs. All of these referrals have a basic goal: to begin immediate intervention for those risks the youth faces on the street while building a level of trust that will enable the youth to eventually leave the street culture (through family reunification, institutional placement, or participation in a formal or ad hoc independent living program).

Data Collection Activities

The intake worker and examining physician at the clinic use the High Risk Youth Program Encounter Form to record data on:

- the purpose of the visit
- referral sources
- services provided
- diagnosis and disposition
- background information including geographic origin, duration of the runaway episode, mental condition, drug use, and sexual history

The data are fed into a computerized system at CHLA that provides information valuable to evaluating the HRYP, as well as creating a comprehensive database on runaway and homeless children in Los Angeles. A number of other agencies around the country have begun using this form, both because of its intrinsic utility for case management and program evaluation purposes and in order to gather important, quality data on homeless and runaway youth that can be easily compared with data from other locations.

The Risk Reduction Program

The Risk Reduction Program targets youth who are infected with HIV or are at high risk of becoming infected because they are involved in survival sex, prostitution, or injectable drug use. It has three primary activities, described below.

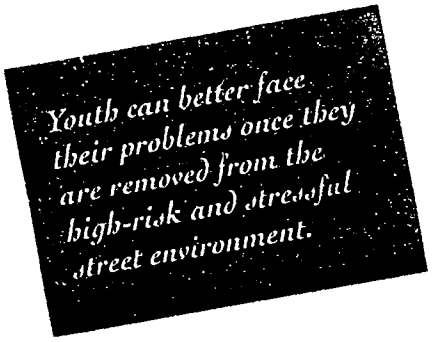
The first is the Risk Reduction Clinic, which is based at the CHLA's Teenage Health Center. Because the Risk Reduction Clinic is based at a hospital, it can offer far more sophisticated medical care than is possible at the L.A. Free Clinic. In addition to medical services for HIV-infected youth, the Risk Reduction Clinic offers HIV antibody testing (and pre- and post-test counseling), health education, risk assessment and risk reduction counseling, health education, case management, and individual and family therapy. Medical care for youth under 21 is paid by the California Children's Services, a state agency, and thus can be provided to clients at no cost. The director of the Risk Reduction Program often participates in the triage process at the HRYP clinic to help decide which clients are most appropriate for referral to the Risk Reduction Clinic.

The other two activities of the Risk Reduction Program are funded through a grant from the Centers for Disease Control. Using these funds, the HIV/AIDS Prevention Project (which administratively is part of the Risk Reduction Program):

- contracts with the Gay and Lesbian Community Service Center for an HIV educator who is used by a number of shelters and youth-serving agencies in the county
- contracts with a number of agencies for outreach teams that patrol areas frequented by runaway and homeless youth and provide HIV education, curbside counseling, condoms, and bleach. These outreach workers also attempt to get youth to make use of the services offered by the HRYP Clinic or one of the participating drop-in centers or shelters as a first step toward leaving the streets. These outreach teams (as well as others operated by other programs in Los Angeles County) meet monthly to schedule and coordinate activities, standardize messages on HIV, and share information.

The Risk Reduction Program is an example of how, through innovative funding distribution, the High Risk Youth Program is able to augment existing services for runaway and homeless youth, provide new services, and coordinate services to maximize their effectiveness and minimize service duplication. The director of the Risk Reduction Program, through involvement in the High Risk Youth Clinic, augments the staff of that program and provides an important source of referrals for the Risk Reduction Clinic. All of the staff of the HIV/AIDS Prevention Project

are hired through subcontracts through other programs. This expands the capabilities of these programs, funding positions that either would not exist or would remain part-time without the HIV/AIDS Prevention monies. These staff members have caseloads or other responsibilities at their own projects and participate in activities (such as HIV education or outreach teams) that few of the programs could afford on their own. And the centralized funding provided by this and other HRYP activities (such as the Substance Abuse Treatment Program described below) guarantees participation in such networking and cooperative ventures as the High Risk Youth Clinic, the Coordinating Council, and the caseworker and outreach meetings.



The Substance Abuse Treatment Program

The Substance Abuse Treatment Program provides assessment, counseling, and outpatient treatment to stabilize and treat youth who abuse alcohol or other drugs. The first priority of the Substance Abuse Treatment Program is placement at a shelter or residential program. Youth can better face their problems once they are removed from the high-risk and stressful street environment. Hospital placements are found for clients in need of detoxification services.

Although youth enter this program through a number of referral sources, the Substance Abuse Treatment Program prefers that they receive the HRYP clinic's medical and psychosocial screenings prior to their involvement with the program.

The Substance Abuse Treatment Program also contracts with a number of emergency shelters, allowing them to hire full-time substance abuse specialists. Counselors from the Substance Abuse Treatment Program sometimes accompany the Mobile Health Team (described below) to the shelters that do not have staff specialists in this area.

The Mobile Health Team

The Mobile Health Team is primarily funded through the McKinney Health Care for the Homeless Act. This team of nurse practitioners and social workers conducts physical and psychosocial examinations in shelter and drop-in facilities and, when appropriate, refers youth to the more intensive diagnostic and medical services available at the HRYP clinic, the Risk Reduction Program, or the Substance Abuse Treatment Program. Some of its members also have caseload and counseling responsibilities at the HRYP Clinic.

The Coordinating Council for Homeless Youth Services

The Coordinating Council for Homeless Youth Services was established as part of an Office of Juvenile Criminal Justice Homeless Youth Pilot Project grant authorized by the Homeless Youth Act of 1985. The council organizes quarterly meetings and ongoing networking activities for virtually every agency providing care to runaway and homeless youth in Los Angeles County, including the High Risk Youth Program and various emergency youth shelters, drop-in centers, outreach projects, transitional living programs, the Gay and Lesbian Community Service Center, the police and sheriff's departments, and the county departments of probation, children's services, mental health, and public health. Periodic meetings are also held for case workers, substance abuse staff, and outreach workers to coordinate activities, standardize messages, and share information.

Project PACE

Project PACE (People Against Child Exploitation) subcontracts with shelters to provide beds for and expertise in dealing with youth involved in prostitution. Another PACE subcontract provides staff training on how to identify and work with youth involved in prostitution and children who have been sexually abused. This training, for the various member agencies, is conducted by Children's Institute International. It also covers issues such as homophobia, survival sex, reporting laws, working with the Division of Children's Services, and the HEADSS interview.

Other Components of the Los Angeles Youth Care System

Shelters, Residential Programs, and Drop-in Centers

Los Angeles County is home to a number of drop-in and residential programs for runaway and homeless youth. Many of these shelters are supported in part by contracts and grants coming through the Division of Adolescent Medicine and/or make use of services provided by the HRYP (such as the Mobile Health Team). Whenever possible, a youth who requests shelter, either at one of the short- or long-term shelter facilities, or through contact with outreach or clinic staff, will be placed in the shelter that best meets his or her needs. First- or second-time runaways who are candidates for immediate family reunification will be referred to one of the short-term shelters, such as Stepping Stone. Chronic runaways and street youth will be referred to one of the longer-term stabilization programs, such as the Los Angeles Youth Network or Citrus House.

These programs collaborate with each other, as well as the components of the HRYP, in a number of other ways including:

- membership in the Coordinating Council for Homeless Youth Services
- participation in the case management and outreach team coordination meetings
- use of the Mobile Health Team for on-site examinations and referral of clients to the HRYP clinic
- on-site HIV prevention activities and staff training through staff of the Gay and Lesbian Community Service Center (GLCSC) funded through the Risk Reduction Project

The HRYP also directly funds beds and staff members (including substance abuse agency specialists and street outreach workers) at several agencies through the Risk Reduction and Substance Abuse Treatment Programs.

The Runaway Adolescent Pilot Program

The HRYP and its affiliated agencies work closely with the Runaway Adolescent Pilot Project (RAPP), a project of the County of Los Angeles Department of Children's Services. RAPP is designed to locate long-term placements for youth who cannot, or will not, return to their homes, yet are too young for independent living programs.

Most RAPP clients are referred by one of the shelters. If a youth calls the program on his or her own, RAPP will encourage the youth to enter a shelter. This guarantees that the youth is in a safe place while RAPP investigates the case and provides a period of stabilization, which is usually necessary before a youth accustomed to the freedom of the streets can make the successful transition to the more structured environment of a long-term placement. To be eligible for a RAPP placement, the youth must also agree to go to school and participate in counseling.

During the time the youth is in the shelter, RAPP will contact his or her family and give the parents an opportunity to sign a voluntary placement agreement. This allows RAPP to place the client in a small group or foster home for six months (a placement paid for by the county). After this six-month period, the case is re-evaluated. If RAPP staff feel that family reunification is still not a possibility, a non-detain petition is filed with the court. This petition makes the client a ward of the court, enabling RAPP to find a placement for the youth until he or she is 18, and also making the client eligible for federal monies to support this placement (relieving the county of some financial burden).

RAPP has found that runaway and homeless youth are served much better in small group homes than in larger institutions and has cultivated relationships with several such homes that primarily serve RAPP placements. This has allowed the staffs of these facilities to develop an expertise in working with runaway and homeless youth. It also allows RAPP caseworkers to visit several clients at one location and handle a caseload above that of other county caseworkers, who typically spend a large part of their day driving from one foster home or institution to another.

Conclusion

While it would be impossible to replicate the HRYP without a major source of funding and a lead agency willing to make a long-term commitment, other programs can learn much from this program's

- use of collaborative arrangements to provide a set of comprehensive services which no single agency would be able to provide
- ability to integrate prevention and intervention efforts targeted at behaviors that put youth at risk of HIV infection into most components of this system

While the constellation of services and agencies put together by the Childrens Hospital Los Angeles represents one of the most comprehensive systems of intervention and care for runaway and homeless youth in the United States, other models have been developed. The Runaway and Youth Network of Allegheny County in Pennsylvania, for example, is a multidisciplinary network of 80 community service professionals who have

- designed and implemented educational activities for the general public about the issue of runaway and homeless youth
- cooperated in providing specialized trainings (on subjects such as Satanism and ritual abuse) to the staffs of member agencies
- developed and implemented a data collection system using the forms created by the LA HRYP
- worked collaboratively to obtain grant monies to augment and improve individual members' services
- opened and maintained lines of communications regarding both individual cases and programmatic activities

It is hard to imagine a community, large or small, urban or rural, in which some form of collaboration around this problem would not prove beneficial to runaway and homeless youth and the agencies that serve them.

With the exception of one coordinating position funded by the Office of Child Development at the University of Pittsburgh, this network is solely supported by in-kind contributions of staff time from participating agencies.

Alexandria, Virginia, is another community that has begun to effectively coordinate services for runaway, homeless, and other youth in high-risk situations. In many communities, the failure of a youth, and/or the youth's family, to take advantage of, or respond to, services for habitual running away may result in a court petition and secure detention or foster placement. In Alexandria, a petitioning of a youth as a Child in Need of Supervision (CHINS) results in a referral to a panel convened and coordinated through the Court Services Unit (the intake mechanism for the juvenile court). This panel will convene a group representing virtually every mental health, social service, and law enforcement agency that has had contact with the youth (and the youth's family). With one agency acting as case manager for the family, an assessment will be made of their needs, and an intensive and coordinated effort will be made to provide services to the family in ways that reduce the level of conflict, preserve the family, and avoid the placing of the youth in a secure detention facility or foster home.

Any collaborative system of meeting the needs of runaway and homeless youth has to take into account the scale of the problem in the community in which it is to take place, as well as the level of resources available in that community. It is hard to imagine a community, large or small, urban or rural, in which some form of collaboration around this problem would not prove beneficial to runaway and homeless youth and the agencies that serve them.

NOTES

1 United Way Planning Council. "Runaway youth situation in Los Angeles County: A general overview."

2 Robertson. "Homeless youth: An overview of recent literature."

3 Yates, MacKenzie, Pennbridge, and Cohen. "A risk profile comparison of runaway and non-runaway youth."

Conclusion

Assisting runaway and homeless youth to reduce the risks they face while out of the home is a daunting task. The absence of a supportive family, distrust of adults and social service institutions, and the emotional consequences of years of neglect, abuse, and exploitation do not make these youth an easy population to reach. The lack of accessible treatment for those who abuse alcohol and other drugs, including long-term residential programs for those who cannot live with their families and are too young to enter independent living programs, and other necessary social, medical, and educational services creates immense obstacles even for those programs whose staff can obtain the trust and participation of youth. Despite the commitment of the federal government to fund programs to serve these youth and to provide the continuum of services they need to make positive improvements in their lives, money is still scarce, staff are overworked, and burnout is high.

The process of assisting a chronic runaway or homeless youth to re-enter society can be a lengthy one. It may start with the occasional contact with a street outreach worker, progress through visits to a free medical center or drop-in program for showers, proceed to participation in counseling sessions and GED programs, and culminate in family reunification, foster care, or graduation from a transitional living program. All of this takes time. Yet, the behaviors that can result in HIV infection take almost no time at all. One sex act in exchange for a meal or a place to sleep during a winter cold snap, one bad choice in a search for the affection and warmth which so many of these youth desire, one instance of being unable to negotiate the use of a condom because one was afraid, or drunk, or simply did not care, can result in HIV infection, AIDS, and death.

The difference between the planning, hard work, and level of resources necessary to help youth protect themselves from HIV, and the momentary lapse that can result in their infection, seems unfair. Yet that is what those agencies and individuals whose agenda it is to help these youth must face. While the future of these youth often looks grim, youth workers do have success stories to tell: stories of seemingly irreconcilable family conflicts that have been worked out, stories of youth who have gone from the streets to college, and stories of smaller behavioral change, including youth who no longer are dependent on alcohol or other drugs for support, who no longer sell their bodies, who consistently use condoms and other means of protecting themselves during sex.

All these victories, both large and small, require the implementation of HIV prevention activities throughout the continuum of services needed by these youth. This is not necessarily an easy task. It requires time and training, both of which translate into additional costs for programs, many of which are already living on the fiscal brink. It is all too easy for programs to spend their money elsewhere. They may feel that the incidence of HIV infection in their area is low enough that it does not warrant the outlay of funds to address this issue in their program. They may feel that their clients are not engaging in those behaviors that put them at risk of HIV infection. They may not want to subject themselves, their staff, and their community to the psychological discomfort of having to explicitly address issues of sexual behavior and mortality. A program that does not do so, however, is making a mistake. Research into the sexual behaviors of high school students reveal that almost every high school will have at least some students who engage in the sexual behaviors that increase the risk of HIV infection. While HIV incidence varies throughout the country, it exists everywhere. Programs that ignore the facts that a significant percentage of adolescents are sexually active, that HIV exists in every state in the nation, and that the youth served by programs for runaway and homeless youth are usually at higher risk for HIV infection than those in the general population, do so at their own risk. It is precisely those programs, and those communities, most in denial about HIV and the behaviors that contribute to its spread that will face the most abrupt shock when, inevitably, they are forced to face the issue.

The challenge of helping runaway and homeless youth to protect themselves from HIV infection is a daunting one. We hope that *Nowhere to Run* has provided some help to those engaged in this critical task.

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Note: The following materials have not been reviewed by the authors, although all come from sources noted for the quality of their products. Many of the books and articles included in the bibliography are also useful for educating administrators, staff, and others about HIV, HIV prevention, and other relevant issues. We have not included prices because these often change.

HIV

■ Adolescents, AIDS and HIV: Resources for Educators
Volume V, November 1990.

Thirteen page bibliography of curricula, pamphlets and brochures, videos, and resources for leaders. Many of the materials are designed for those working with special populations, such as gay and lesbian youth, Latino youth and African American youth. Also specifies which resources are available in Spanish.

Center for Population Options
1025 Vermont Avenue, N.W., Suite 210
Washington, DC 20005
(202) 347-5700

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■ Adolescents: At Risk for HIV Infection
1991.

Developed in part to make information about HIV and AIDS more accessible and less threatening, this video is based on interviews with experts on HIV/AIDS who work with adolescents, and focuses on three major areas: behaviors that place teenagers at risk, prevention strategies, and issues of counseling, testing, and follow-up.

Child Welfare League of America
c/o CSSC
P.O. Box 7816
300 Raritan Center Parkway
Edison, NJ 08818-7816
(202) 638-2952

■ AIDS Laws for Mental Health Professionals
1990.

Gary James Wood and Robert Marks, with James W. Dilley

AIDS Health Project
Box 0884
San Francisco, CA 94143-0884
(415) 476-6430

- AIDS Prevention for Youth
  1989.

  A video and training package designed to use with youth in short-term crisis intervention settings. The materials address knowledge, attitudes, and behaviors of AIDS prevention. (Training necessary).

  Southeastern Network Of Youth & Family Services
  337 S. Milledge Avenue
  Suite 209
  Athens, GA 30605
  (706) 354-4568

- Caring for Someone With AIDS
  1989.

  This 14-page booklet provides information on being a caretaker for someone with HIV infection. Includes information on how to handle food, clean up spills that contain body fluids, and information on other diseases that may result from HIV infection. Aiso provides basic facts about HIV transmission and discusses the mental health of both a person with HIV infection and the caretaker. Free.

  National AIDS Clearinghouse
  (800) 458-5231

- A CAES for Safety: HIV/AIDS Prevention Project Curriculum
  1993.

  Staff training manual, which includes a ten-part module. Client training manual includes series of "fun and games" of serious HIV/AIDS prevention.

  Massachusetts Committee for Children & Youth
  14 Beacon Street, Suite 706
  Boston, MA 02108
  (617) 742-8555

- Courage To Care
  1990.
  Gary Anderson (Ed.)

  A comprehensive review of the implications of AIDS on individuals, families, and society, written for those who treat and offer care to children, youth, and families infected with the HIV virus. Includes chapters on Reaching Out to High-Risk Adolescents, Prevention Education for Adolescents, and HIV Antibody Testing and Counseling: Crisis and Coping for Adolescents and Adults. Concludes with extensive appendices with resource groups, print and audiovisual materials, and reprints on HIV from the American Academy of Pediatrics.

  Child Welfare League of America, Inc.
  440 First Street, N.W.
  Suite 310
  Washington, DC 20001-2085

- Effective AIDS Education: A Policymaker's Guide
  1988.

  This 13-page document provides a discussion about collaborative efforts to prevent the spread of HIV infection in young people. Targeted at schools, but useful for other youth-serving organizations.

  National Association of State Boards of Education (NASBE)
  1012 Cameron Street
  Alexandria, VA 22314
  (703) 684-4000

- A Guide to Implement Tap: Teens for AIDS Prevention by the Center for Population Options
  1990.

  This guide includes how to begin planning and implementing an HIV and AIDS peer program for young people. It also presents a detailed training curriculum for preparing young people to conduct educational workshops, develop media campaigns, and other prevention activities around HIV and AIDS.

  Center for Population Options
  1025 Vermont Avenue, N.W., Suite 210
  Washington, DC 20005
  (202) 347-5700

- HIV and the Health Care Worker
  Sixth Edition, January, 1991.

  This 12-page booklet provides information on how to prevent HIV infection on and off the job. It explains in layperson terms how to use universal precautions. It also explains that when you have casual contact with a client, such as intake or bringing food, there is no need to use universal precautions. Directions on how to handle exposure to blood are also given.

  Service Employees International Union (SEIU)

  1313 L Street, N.W.
  Washington, DC 20005
  (202) 898-3386

- HIV and Homeless Youth: Meeting the Challenge
  1990.

  This thorough manual describes the program developed at Larkin Street Youth Center for prevention of, education about, testing for, and treatment of AIDS among adolescents in high risk situations. Includes actual policies and forms developed and used by Larkin Street covering such topics as confidentiality, discrimination, counseling, employees, consent form for HIV antibody testing, and release of information.

  Larkin Street Youth Center
  1044 Larkin Street
  San Francisco, CA 94109
  (415) 673-0911

- HIV Infection and AIDS: Are You At Risk? and AIDS Prevention Guide
  n.d.

  Brochure and packet of information from the Centers for Disease Control that provides basic and straightforward information about HIV and AIDS, ways to prevent it, and strategies for reaching youth.

  Department of Health and Human Services
  Public Health Service
  Centers for Disease Control
  National AIDS Hotline
  1-800-342-2437
  1-800-344-7432 (Spanish)
  1-800-243-7889 (TTY)

- Living with AIDS: Perspectives for Caregivers
  1989.

  This manual reflects St. Francis Center's outstanding counseling experience regarding HIV infection. The manual is designed to help health care and social service professionals, community volunteers, family members, and friends explore the emotional issues faced by people living with AIDS and HIV infection.

  St. Francis Center
  5417 Sherier Place, N.W.
  Washington, DC 20016
  (202) 363-8500

- No Longer Immune: A Counselor's Guide to AIDS
  1989.
  Craig Kain (Ed.)

  This textbook-styled guide includes a comprehensive chapter, "Special Needs of Today's Adolescents." Issues of gay and lesbian youth, homophobia, cultural sensitivity, and other topics are covered.

  American Association for Counseling and Development (AACD)
  5999 Stevenson Avenue
  Alexandria, VA 22304
  (703) 823-9800

- On Their Own: Runaway and Homeless Youth and Programs That Serve Them
  1991.
  Sheila A. Pires and Judith Tolmach Silber

  Monograph that describes who homeless and runaway youth are, what their needs are, and the kind of services that are being provided in seven communities around the country. Includes a section on AIDS prevention and education and has several appendices, including one with excerpts from AIDS Education and Training Manuals.

  Children and Youth At Risk Project
  CASSP Technical Assistance Center
  Georgetown University Child Development Center
  2233 Wisconsin Avenue, N.W., Suite 215
  Washington, DC 20007
  (202) 338-1831

- Out of the Shadows: Building an Agenda and Strategies for Preventing HIV/AIDS in Street and Homeless Youth
  1990.

  Wanda Wigfall-Williams
  Center for Population Options
  1025 Vermont Avenue, N.W., Suite 210
  Washington, DC 20005
  (202) 347-5700

- Peer Education. Teens Teaching Teens about AIDS and HIV Infection Prevention
  1990.

  This booklet discusses the background and the elements of peer education and applies it to HIV and AIDS. Four peer education programs directed at both in- and out-of-school are briefly described, and tips for working with teens are provided.

  Center for Population Options
  1025 Vermont Avenue, N.W., Suite 210
  Washington, DC 20005
  (202) 347-5700
  (202) 347-2263 (Fax)

- Peer Leadership Preventing AIDS Curriculum
  1991.

  A twelve-session curriculum for teachers, youth workers, and others to train peer leaders to present accurate information on AIDS and foster in others the skills to choose health behaviors that reduce the risk for HIV.

  Peer Leadership Preventing AIDS
  The Medical Foundation
  95 Berkeley Street
  Boston, MA 02116
  (617) 451-0049, ext 217

- Safe Choices Guide: AIDS and HIV Policies and Prevention Programs for High-Risk Youth
  1990.

  A complete HIV and AIDS manual, specially designed for shelter and agency staff who serve youth in high-risk situations. It covers topic ranging from policy development to training foster parents.

  National Network of Runaway and Youth Services
  1319 F Street, N.W.
  Washington, DC 20004
  (202) 783-7949

- SIECUS Report
  February/March 1990, Volume 18, Number 3.

  Special issue on "Cultural diversity and sexuality/AIDS information and education."

  Sex Information and Education Council of the United States
  32 Washington Place
  New York, NY 10003
  (212) 673-3850

- Teaching Safer Sex
  1989.

  Peggy Brick, Catherine Charlton, Hillary Kunins, & Steve Brown
  This resource guide is full of creative and effective educational exercises around sexuality and safer sex. It is useful for both educators and counselors.

  Center for Family Life Education
  Planned Parenthood of Bergen County, Inc.
  57 Main Street
  Hackensack, NJ 07601
  (201) 489-1265

The Abuse of Alcohol and other Drugs

- Alcohol & Substance Abuse Prevention Implementation Manual for the ASAP Program

  This implementation guide presents a step-by-step explanation of how to implement the Alcohol and Substance Abuse Prevention Program. The goals of the program are to reduce excess morbidity and mortality rates among multi-ethnic middle and high school students and to empower students. The guide covers the theoretical basis of the program, planning the role of a facilitator, facilitator training, community involvement, and evaluation.

  ASAP Program Manager
  Family Practice Center, School of Medicine
  University of New Mexico
  Albuquerque, NM 87131
  (505) 277-5532

- Drug Use Among Runaway Youth: A Southeastern Perspective

  This report provides a statistical comparison of drug use of runaway youth compared to in-school youth.

  Southeastern Network of Youth and Family Services
  337 S. Milledge Avenue Suite 209
  Athens, GA 30605
  (404) 354-4568

- Friendly Peersuasion

  This 20-hour curriculum targets girls in high-risk situations ages eleven to fourteen and uses a cross-age peer leadership approach to substance abuse prevention and education. It is designed to train girls to help their peers choose healthy and productive alternatives to substance abuse.

  Girls Incorporated
  National Resource Center
  441 West Michigan Street
  Indianapolis, IN 46202
  (317) 634-7546

- Meeting Life's Challenges: A Youth Worker's Manual on Alcohol and Drug Issues and Interventions

  This manual provides information on how to conduct chemical dependency assessments and on family dynamics and parenting as they relate to alcohol and other drug use. It also includes session outlines for leading groups with parents and young people.

  Oasis Center, Inc.
  1216 17th Avenue, South
  P.O. Box 121648
  Nashville, TN 37212
  (615) 320-0026

- On Their Own: Runaway and Homeless Youth and Programs That Serve Them 1991.
  Sheila A. Pires and Judith Tolmach Silber

  Monograph that describes who homeless and runaway youth are, what their needs are, and the kind of services that are being provided in seven communities around the country. Includes a section on Substance Abuse Prevention, Education, and Treatment.

  Children and Youth At Risk Project
  CASSP Technical Assistance Center
  Georgetown University Child Development Center
  2233 Wisconsin Avenue, N.W., Suite 215
  Washington, DC 20007
  (202) 338-1831

- Recovery Assistance Program: A Teacher's Guide to Drug and Alcohol Recovery Education

  This guide provides a curriculum that is designed to provide students impeded by substance abuse with a drug-free, supportive, and structured learning environment. The program assists students in developing social and learning skills to function successfully. The curriculum addresses personal responsibility, interpersonal communication, self care, feelings, and time management.

  King County Division of Alcoholism and Substance Abuse Services
  Seattle-King County Department of Public Health
  108 Smith Tower
  506 Second Avenue
  Seattle, WA 98104
  (206) 296-7615

- The Runaway and Substance Abuser: A Basic Course For Youth Workers by the Michigan Network for Runaway and Youth Services

  This package includes eight 20-minute video tape modules. It is useful to entry-level youth care workers to introduce them to several basic aspects of adolescent substance abuse.

  The Michigan Network of Runaway and Youth Services
  115 W. Allegan, Suite 310
  Lansing, MI 48933
  (517) 484-5262

- Social Detoxification for Adolescents

  Curriculum was developed by Heartview Treatment Center in Mandan, North Dakota, for Mountain Plains Youth Services. On video.

  Mountain Plains Youth Services
  709 East Third
  Anaconda, MT 59711
  (701) 255-7229

- Substance Abuse Training by the Southeastern Network of Youth & Family Services

  A manual and training package for runaway center staff to utilize in assessing and intervening with substance abusing adolescents. Includes exercises and plans for prevention programs.

  Southeastern Network of Youth & Family Services
  337 S. Milledge Avenue, Suite 209
  Athens, GA 30605
  (404) 354-4568

- The Youth Drug Free Challenge Project: A Counselor's Guide by the Highline Youth Service Bureau

  This manual provides a detailed curriculum for leading a group of young people who abuse alcohol or other drugs and for leading a group of their parents. It also addresses its treatment philosophy, group structure, and evaluation.

  King County Division of Alcoholism and Substance Abuse Services
  Seattle-King County Department of Public Health
  108 Smith Tower
  506 Second Avenue
  Seattle, WA 98104
  (206) 296-7615

- Youth-Reaching-Youth Implementation Guide: A Peer Program for Alcohol and Other Drug Use Prevention

  This guide provides detailed instruction on how to adapt the Youth-Reaching-Youth Program in community-based agencies. Topics addressed include hiring staff, developing agency policies, developing a budget, recruiting and supervising peer leaders, and developing a program evaluation. It also includes a 42-hour curriculum designed to train young people to effectively work with runaway and homeless youth.

  National Network of Runaway and Youth Services
  1319 F Street, N.W.
  Washington, DC 20004
  (202) 783-7949

- Adolescent Maltreatment

  An analysis of 2,500 youth who have run away and have been physically and sexually abused. This document profiles this population and provides information concerning their service needs.

  Southeastern Network of Youth & Family Services
  337 S. Milledge Avenue, Suite 209
  Athens, GA 30605
  (404) 354-4568

- Bridges of Respect: Creating Support for Lesbian and Gay Youth
  Katherine Whitlock

  American Friends Service Committee
  1501 Cherry Street
  Philadelphia, PA 19102
  (215) 241-7000

- Life Planning Education

  A curriculum designed to help teenagers prepare for the decisions they will make about health, sexuality, parenthood, and work. Topics covered include personal values, decision making, employment, HIV/AIDS, and good communication.

  Center for Population Options
  1025 Vermont Avenue, N.W., Suite 210
  Washington, DC 20005
  (202) 347-5700

- Peer Education in Sexuality and Health

  This manual explains the administrative and planning details of setting up and implementing a peer program. It covers teen recruitment and selection, empowering teens, training topics, fundraising, hiring staff, and building community support.

  Program Services Division
  YWCA of the U.S.A., National Board
  726 Broadway
  New York, NY 10003
  (212) 614-2833

- SOS Runaways and Teen Suicides: Coded Cries for Help
  Sally Brown, M.S.W.

  This runaway-suicide-prevention training manual includes a 12-hour training to provide a common base of knowledge and skills to runaway shelter staff for understanding the depressed or suicidal adolescent, recognizing clues and coded messages that indicate a potential for suicide, assessing the level of suicidal risk, and appropriate intervention.

  Human Services Development Institute
  University of Southern Maine
  96 Falmouth Street
  Portland, ME 04103
  (207) 780-4430

- Why Me? Help for Victims of Child Sexual Abuse (Even if They are Adults Now)

  Provides guidelines and personal stories for survivors of child sexual abuse (who are now teenagers or adults) to help facilitate understanding and healing. Counselors will find this book useful in working with clients who were sexually abused.

  ETR Associates/Network Publications
  P.O. Box 1830
  Santa Cruz, CA 95061-1830
  (800) 321-4407

- The AIDS Health Project
  University of California San Francisco
  Box 0884
  San Francisco, CA 94143-0884
  (415) 476-6430

  Publishes HIV and AIDS-related periodical, brochure, video and books for professionals.

- Centers for Disease Control
  Atlanta, GA

  National AIDS Hotline
  (800) 342-2437
  (800) 344-7432 (Spanish)
  (800) 243-7889 (TTY)

  Provides confidential information, referrals and educational material on AIDS

  National AIDS Information Clearinghouse
  P.O. Box 6003
  Rockville, MD 20850
  (800) 458-5231

  Provides reference assistance, referrals to organizations providing AIDS-related services, and copies of selected government approved publications including HIV/AIDS Monthly Surveillance Report. Spanish speaking staff are available.

  Monthly HIV/AIDS Taped Recording
  (404) 330-3020

- Hetrick-Martin Institute for Lesbian and Gay Youth
  401 West Street
  New York, NY 10014
  (212) 633-8920

  Contact for information about its peer education project for HIV prevention. Publishes comic books and other useful materials for outreach to youth in high risk situations.

- IMPACT AIDS Incorporated
  3692 18th Street
  San Francisco, CA 94110
  (415) 861-3397
  IMPACT AIDS disseminates educational materials developed by the San Francisco AIDS Foundation.

- National Association of People with AIDS (NAPWA)
  2025 I Street, N.W.
  Suite 1101
  Washington, DC 20006
  (202) 429-2856

  This organization provides support in various ways for people who are HIV positive. NAPWA also has a speakers bureau and will assist you in your search for an appropriate speaker.

- The National Clearinghouse for Alcohol and Drug Information (NCADI)
  P.O. Box 2345
  Rockville, MD 20852
  (800) 729-6686

  NCADI is a service of the Office for Substance Abuse Prevention which promotes and distributes prevention materials and general government publications on alcohol and other drug topics.

- National Clearinghouse on Runaway and Homeless Youth (NCRHY)
  P.O. Box 13505
  Silver Springs, MD 20911-3505
  (301) 608-8098

  NCRHY is a national resource for youth service professionals, policymakers, and the general public. It distributes information about successful program approaches, available resources, and current activities relevant to programs serving runaway and homeless youth.

- National Coalition of Hispanic Health & Human Services Organizations (COSSMHO)
  1501 16th Street, N.W.
  Washington, DC 20036
  (202) 387-5000

  COSSMHO is dedicated to improving the health and psychosocial well-being of the nation's Hispanic population. One of COSSMHO's projects is AIDS Education for Out-Of-School Hispanic Youth. As part of the project a video on youth peer counseling, *Each One, Teach One*, has been produced. The video shows their youth theatre group in action. For more information call Concha Orozco at (202) 387-5000.

- National Council of La Raza (NCLR)
  810 1st Street, N.E.
  Washington, DC 20002
  (202) 289-1380

  NCLR provides policy, technical assistance, and advocacy for Hispanic-serving community organizations. Its AIDS Training and Reference Materials (a train-the-trainer manual) includes topics on creating coalitions, understanding funding sources, writing proposals, and hands-on activities to support these topics. Contact Miquel Gomez or Ofelia Ardon at La Raza AIDS Center (202) 289-1380 for more information.

- National Native American AIDS Prevention Center (NNAAPC)
  6239 College Avenue, Suite 201
  Oakland, CA 94618
  (415) 658-2051

  This organization provides referrals and educational materials, including a newsletter entitled *SEASONS*.

- The National Network of Runaway and Youth Services (NNRYS)
  1319 F Street, N.W., Suite 401
  Washington, DC 20005
  (202) 783-7949

  The NNRYS provides training and technical assistance for the Safe Choices program. For technical assistance on HIV prevention call the Safe Choices Hotline at (800) 878-AIDS.

- National Resource Center for Youth Services (NRCYS)
  The University of Oklahoma
  202 West Eighth Street
  Tulsa, OK 74119-1419
  (918) 585-2986

  The NRCYS markets many of the materials listed above, along with others of interest to programs serving runaway and homeless youth. A comprehensive catalog of publications, videos, and training programs is available.

- National Runaway Switchboard
  3080 North Lincoln
  Chicago, IL 60657
  (800) 621-4000

  The National Runaway Switchboard facilitates communication among youth, their families, and community-based resources. It also distributes information, brochures, posters, and other materials.

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